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BREASTFEEDING  
and the  
SOCIAL CONTROL  
OF WOMEN

by

Celia Dyball, B.A.(Hon.)(Open)

Thesis submitted for the degree of Ph.D. at the Open University

Discipline: Family Research Group

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## **ABSTRACT**

Breastfeeding remains problematic in our society despite its being a 'natural' physiological process, its official encouragement as the healthiest way to feed babies and its revival in popularity amongst mothers over the last thirty years. Many mothers give up early and turn to bottle-feeding, and a substantial minority choose not to breastfeed at all. The aim of this research was to study mothers' feeding experiences in the context of the culture and organisation of western industrialised society. The small sample from a single area, whilst not claiming to be rigorously representative, was drawn nevertheless from a community which was very much the product of western industrialised society.

Three in-depth interviews were conducted with 47 mothers having their first babies. The first interview was less than a month before the birth, the second about a month after, and the third at about five months. Most wanted to breastfeed, but found it a struggle against doubts and difficulties stemming from lack of knowledge, conflicting ideas and cultural embarrassment. Even those who continued breastfeeding were dependent on bottle-feeding to overcome problems.

Health education on the benefits of breastfeeding and coherent advice based on 'demand feeding' will not solve problems stemming from cultural embarrassment and incompatibility with other culturally defined duties and social activities, but setting an unattainable 'natural ideal' could contribute to women's feelings of guilt or failure when they compromise with bottle-feeding, or choose not to breastfeed at all.

**CHAPTER 1: INTRODUCTION**

The purpose of this study is to examine women's experiences of breastfeeding in a western industrialised society from a feminist perspective. Over the past twenty five years research interest in breastfeeding has grown, stimulated by unease about its decline and evidence of health problems in artificially fed babies. Feminist research has also grown, with various aspects of women's lives being scrutinised for ways in which men exert social control over women's bodies and lives. But only recently have the two research interests come together with the feminist perspective being applied to breastfeeding (Van Esterik, 1989). The focus here is not just on the difficulties faced by breastfeeding mothers, but also on how those experiences reflect and are affected by the power relations of the social context in which mothers undertake to feed their babies.

Interest in breastfeeding by health officials was stimulated by the accumulation of evidence linking artificial feeding with health problems in babies. This century saw a decline in breastfeeding in advanced industrialised countries, especially after World War II, until in the 1960s artificial feeding had become the norm. In 1967 in the USA only 25 % of mothers were breastfeeding when discharged from hospital (Minchin, 1985, p.216). In Britain a Government Working Party reviewed various surveys of breastfeeding rates in the 1960s and early 1970s and concluded that, '...the United Kingdom is largely an "artificially fed" or "bottle feeding" nation, in which cows' milk (rather than the milk of any other animal) is used as a food for infants instead of human milk.' (Department of Health and Social Security (DHSS), 1974, p.4). Although the medical establishment had acquiesced in the spread of artificial feeding, there had never been universal agreement as to its desirability. By the 1970s it was being blamed for

problems in babies such as obesity, diarrhoea and intestinal infections, allergies and hypernatraemia<sup>1</sup>. It was also implicated in the sudden death syndrome (cot death) although no direct cause was established (Addy, 1976; DHSS, 1977). In 1974 a British government report strongly recommended breastfeeding and stressed the importance of education for prospective parents on the subject (DHSS, 1974). Positive action to encourage breastfeeding and help mothers to accomplish it became a matter of official policy for health professionals involved in maternity care.

The popularity of breastfeeding revived. In 1980 in England and Wales 67% of mothers attempted to breastfeed (DHSS, 1988, p.10). However, this may be the peak of popularity (Taitz, 1990; Howie, 1990). In 1985 the figure had dropped slightly to 65% (DHSS, 1988, p.10), and the Chairman and Chief Medical Officer of the Government's Committee on Medical Aspects of Food Policy said, '...there are warning signs that breastfeeding rates may not be maintained in the future.' (ibid., p.iii). In 1990 63% of mothers attempted to breastfeed, with decreases discernible in certain sub-groups, particularly 'mothers of first babies in Social Class III (non-manual), mothers who left full-time education before the age of eighteen years, mothers under the age of thirty having their first babies' (White et al., 1992, p.xviii). A study in Sheffield found a rapid decline between 1984 and 1988 especially amongst those not educated beyond 18 years and Asian mothers (Emery et al., 1990).

There is also evidence of mothers who attempt to breastfeed soon giving up (Wood, 1990). In 1974 the Government adopted a policy of recommending breastfeeding for four to six months (Martin, 1978, p.1), but the percentage of mothers

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<sup>1</sup>A concentration of sodium in the blood above the normal range (150 millimols per litre) which could result in disturbances in the brain (e.g. convulsions, coma) because of loss of water from the brain cells. (Giangrande, 1991)

still breastfeeding (wholly or partly) at six weeks was 40% in 1985 and 50% in 1990, whilst at four months the figures were 26% in 1985 and 25% in 1990 (DHSS, 1988, p.10; White et al., 1992, p.xv). So, in spite of official encouragement, evidence of its benefits for babies and the increased enthusiasm of mothers to try it, the re-establishment of breastfeeding remains a problem in our society.

Yet breastfeeding is a 'natural' function. Animals which suckle their young are classified as 'mammals', and as human females have this capacity, as a species humans are included in this category. Lactation is one of the physiological consequences of giving birth, and breastfeeding is the biologically given means of sustaining the life of the new-born baby and providing for its physical development. Through centuries and across cultures human societies have depended on breastfeeding as part of the process of bringing new generations into the world: it is part of the process of reproduction. There is no reason to assume that women living in advanced industrialised societies have lost this physical capacity. According to the World Health Organisation at least 97% of women are physiologically capable of breastfeeding their babies successfully (Royal College of Midwives (RCM), 1988, p.1).

But human beings are social beings. A woman who breastfeeds is not just a lactating mammal but a member of a society too, occupying a particular position in its social structure and participating in its culture. Like other 'natural' functions (e.g. birth, menstruation, disease, death) breastfeeding is culturally mediated. How it is actually managed and experienced cannot be predicted from biology alone, and will vary in different societal/cultural settings. Does the social and cultural milieu in which women come to feed their babies in Britain today obstruct breastfeeding?

In considering the above question it is necessary to distinguish two effects of

social/cultural obstructions to breastfeeding: those who want to breastfeed are led to give up in face of difficulties, whilst others are led not to want to do it at all. But in the latter case it should be borne in mind that the women themselves would have their own point of view. If they do not want to breastfeed, then it could be that for them the problem is not cultural obstructions to breastfeeding, but pressures to breastfeed from a pro-breastfeeding lobby.

Should this, as a feminist study, be pro-breastfeeding? I first became interested in this topic through my own experiences as a woman trying to mother my babies. When I discovered with my first child in 1975 that wanting to breastfeed was not enough and it did not come 'naturally', I felt a failure. Women's bodies are designed by 'nature' to meet the nutritional needs of their babies until they are mature enough to move on to mixed foods, and yet I was unable to do so without the aid of artificial milk supplements. Later I met and talked with other mothers and discovered I was not alone in my experiences and feelings. I came to realise my failure was a product of my upbringing, which had given me no opportunities to learn about babies, and of the contradictory advice I had received from medical experts. I then felt I had been cheated of the opportunity to experience my full physical abilities, and the sense of achievement and self-sufficiency (which I discovered with my next two babies) of being able to meet my baby's requirements for life and healthy growth entirely from my own body. I felt that feminism should be pro-breastfeeding because I saw breastfeeding as a uniquely female right which women were being denied through social forces beyond their control.

However, within feminism there has been ambivalence on matters appertaining to women's traditional role of mother, including breastfeeding. Stanley & Wise (1983) have argued that the social construction of reality means that there is no one objective



reality, but different views of reality. Women, whether feminist or not, may have different views of breastfeeding grounded in their experience. They therefore warn against a researcher imposing a 'feminist' view on to the experience of the women she is studying, thus denying the validity of their experience.

In Chapter 2 I shall therefore explore the feminist ambivalence on breastfeeding and the necessity for women's reproductive powers to be kept under male control if a male-dominated social order is to be maintained. I shall then explain the difference between a feminist approach to this subject and the non-feminist approach of the pro-breastfeeding groups who have been actively encouraging the breastfeeding revival. Chapter 3 will consider the subordination of women in general in our society, and how women's experiences of reproduction and motherhood are constructed so that these aspects of women's reproductive power and work do not threaten the male-dominated social order. The next two chapters are then concerned with breastfeeding as one particular aspect of motherhood and women's reproductive power. Chapter 4 explains current knowledge about breastfeeding and controversies over actual practice, and Chapter 5 shows how historically breastfeeding has been culturally defined and contained as part of the maintenance of male dominance, a process which includes the rise of bottle-feeding. Chapter 6 considers the methodology of this study, and chapters 7 to 12 analyse the interview data following the chronological process of feeding one's baby from preparations before birth to weaning on to a mixed diet. Chapter 13 concludes the thesis.

## **CHAPTER 2: THEORETICAL ASSUMPTIONS UNDERLYING APPROACHES TO BREASTFEEDING**

### **2.1 FEMINIST STANDPOINTS AND ASSUMPTIONS**

#### **2.1.1 Feminist Ambivalence: Reproduction and Male Dominance**

Basic to feminism is the view that women are oppressed (Abbott & Wallace, 1990). Feminist research has therefore focused on ways in which women lose control over their work, their bodies and their lives to men in a male-dominated social structure. The ideological identification of women with motherhood has been identified as a key feature in women's oppression, and the cultural construction of femininity and motherhood has therefore been subject to critical scrutiny. Thus, in the new-wave feminism of the past twenty five to thirty years, interest in reproduction was at first in terms of freedom from having to be mothers, that is in such issues as free access to safe contraception and abortion. Later feminist interest was taken in motherhood, but feminist attitudes towards women's reproductive role are equivocal (including attitudes towards breastfeeding).

This stems from the fact that 'the feminist perspective' in fact encompasses a multiplicity of perspectives (Abbott & Wallace, 1990). Women's biological reproductive function always features in some way in feminist explanations of women's subordination, but some radical feminists have seen women's biology in itself as the handicap which causes social disadvantages. Thus Firestone (1972) argues that such biological functions as menstruation, menopause and childbirth are physical burdens for women, and that their childbearing and breastfeeding functions result in an interdependence between mother and child which renders them dependent on men for their physical survival. This

gives men a taste of power which they wish to maintain over women. According to Firestone the development of contraceptive technology has brought only limited benefit to women since they are still burdened with the childbearing function. One of the necessities for women's liberation is therefore the development of technology to relieve women of childbearing altogether. According to the logic of this view artificial feeding for babies is a liberating development for women.

De Beauvoir (1953) also sees women's biology as a burden because a greater proportion of women's bodies than men's is for the purposes of reproduction rather than maintaining the health of the individual, and proportionately more of a woman's life is taken up with reproduction. In addition, the functions of the female reproductive system are often uncomfortable and debilitating, and bearing children risks the mother's health and even her life. Men are therefore physically freer to pursue higher cultural activities, transcending nature while women are 'more enslaved to the species' (De Beauvoir, 1953, p.239). By this logic breastfeeding would be one of the physical disadvantages which keep women tied to 'nature' and therefore culturally inferior to men.

Ortner, however, argues (1974) that it is not biology as such which causes women's subordination, but the way in which female biology is culturally defined and evaluated. Levi-Strauss (1969) argued that social order depends on there being a demarcation between 'nature' and 'culture'. 'The prime role of culture is to ensure the group's existence as a group, and consequently...to replace chance by organization.' (p.32) Human beings are part of the natural world, yet through culture they can give meanings to natural events and act purposefully rather than passively move with or be moved by 'nature'. Through culture humans act on and gain control over nature, and cultural activity is therefore defined as superior to 'nature'. Women's bodies and lives

being taken up so much more than men's with the natural functions of reproduction leads to women being culturally defined as closer to nature than men and therefore inferior. But this does not preclude the possibility of cultural redefinition. Therefore, according to the logic of this view, breastfeeding is not intrinsically burdensome but is made so by cultural definition.

Oakley (1980) concentrates more on the need to control reproduction culturally. Giving birth is a natural event which, like all natural events, has to be culturally contained because otherwise such events would bring an arbitrariness and randomness which would threaten social order. Therefore, there are recognised rules, norms or customs which regulate practice. Oakley points out that the natural event of giving birth has particularly important social implications for the maintenance of social order since besides providing for the physical continuance of the group, individual births have social implications within the group.

Particular childbirths create or break families, establish the ownership of property and entitlement to poverty or privilege; they may alter the statuses, rights and responsibilities of persons, communities and nations.

(Oakley, 1980, pp.7-8)

For a particular social order to survive, reproduction must be socially controlled, and for men to maintain dominance it must be under male control. How reproduction is controlled and managed is how women are controlled and managed because only women have the power to give birth. According to this view, again, breastfeeding need not be a burden in itself, but rather how it is experienced by women will depend on how it is culturally defined and managed.

Rich (1977) sees the problems of motherhood stemming entirely from the way it is constructed as an institution in male-dominated society. She sees nothing essentially oppressive about bearing or mothering children, but rather sees motherhood as an important, potentially blissful part of female experience. Rich does not see biological functions such as menstruation, pregnancy or giving birth as necessarily burdensome, but rather as part of an entire life-time process of female human experience through which a woman should derive feelings of pleasure and strength. Thus breastfeeding is integrated with other aspects of female experience. 'Beyond birth comes nursing and physical relationship with an infant, and these are enmeshed with sexuality, with the ebb and flow of ovulation and menses, of sexual desire.' (p.183) Therefore women should be able to enjoy breastfeeding as part of female human experience.

#### 2.1.2 Breastfeeding as a Feminist Issue in this Study

Breastfeeding is a capacity unique to women, part of female reproductive power. If there are social and cultural obstructions to women's realisation of this power, then this could be viewed as evidence of women's oppression because it affects only women. One of the concerns of my research is to examine women's experiences for these obstructions and how they contribute to the maintenance of male dominance. This assumes that breastfeeding is made burdensome through cultural definition rather than being intrinsically so. However, this does not mean that the ideological identification of women with motherhood is accepted uncritically, with its assumption that women can only be fulfilled through bearing and mothering children. Rather, it is assumed that women should be in control of their own reproductive power since having to bear children and breastfeed against their inclinations would of course be burdensome.

I shall not therefore dismiss the views of women who do not wish to breastfeed

their babies merely as 'false consciousness' or evidence of alienation from their own bodies. In the context of the mother's experience not breastfeeding could be an act of resistance, a means of asserting some control over her own body and life, or it could represent a solution in the face of conflicting meanings and pressures. This study therefore accepts women's reasons for not breastfeeding (or for giving it up) without seeing their decision as wrong or a failure on their part. On the other hand taking account of women's actual experiences and how they come to make their decisions should shed light not only on the difficulties and obstructions to breastfeeding, but also the position of mothers in society.

### 2.1.3 Patriarchy and Capitalism

The feminist views mentioned so far are usually categorised as 'radical feminism'. They concentrate on gender inequality, seeing men as the oppressors through a system of 'patriarchy'. Rich (1977) has defined patriarchy as:

...a familial-social, ideological, political system in which men - by force, direct pressure or through ritual, tradition, law, and language, customs, etiquette, education and the division of labour, determine what part women shall or shall not play, and in which the female is everywhere subsumed under the male. (p.57)

This does not mean that no woman ever has any power, and of course the specific nature of women's subordination will vary with the ways in which different societies are structurally and culturally organised.

But theorists in the Marxist tradition have put more stress on the production process than reproduction in explaining women's subordination. Thus gender inequality

derives from capitalism rather than an independent system of patriarchy, and the beneficiaries are the owners of the means of production rather than men. Men's domination over women is a by-product of capital's domination over labour (Walby, 1990, p.4). Some feminists (e.g. McDonough & Harrison, 1978; Eisenstein, 1979) attempt in various ways to synthesise Marxist and radical feminist theory, arguing that both systems are present and important in the structuring of today's gender relations. This is 'dual-systems' theory (Walby, 1990, p.5), or 'socialist feminism' (Abbott & Wallace, 1990).

As today's western society is capitalist, with class-based divisions creating inequalities between women, drawing on Marxist theory as well as radical feminist theory in this study would acknowledge class differences between women in our society as well as the differences between the two genders. Also, the Marxist approach provides an alternative line of enquiry as to the function of artificial feeding in the maintenance of power relations. In what follows therefore women's experiences will be examined in terms of the effects of both patriarchy and capitalism.

But first I shall consider how a feminist stance differs from that of those who have been actively working for breastfeeding's revival.

## 2.2 NON-FEMINIST STANDPOINTS AND ASSUMPTIONS

Feminist research is research by and for women, and is concerned with questions of women's needs, rights, etc. Feminist interest in breastfeeding therefore has women as the main focus of attention for their own sake as women. Non-feminist interest in breastfeeding, on the other hand, although paying a great deal of attention to mothers, has ultimately been centred around babies and their needs, with women coming into focus in their role as mothers meeting the needs of their babies. Such interest came as

a response to the rise of bottle-feeding, and has been pro-breastfeeding in the belief that this is the most healthy way to feed babies. It has left unchallenged the ideological identification of women with motherhood, and the cultural view of mothers as wholly dedicated to serving the needs of their babies because this is their means of fulfilment (see Chapter 3).

### 2.2.1 Official Interest in Breastfeeding

Medical and governmental interest in breastfeeding has not been confined to studying it as a physiological process or to analysing the composition of breast milk. Attention has also focused on mothers to discover what social factors are involved in their feeding decisions, and on their experiences to see what problems lead them to give up. Thus it has been established that the factors associated with the highest incidences of breastfeeding are: 'earlier birth order, education of the mother beyond the age of 18 years, high social class, living in London and the South East, and being a mother of 25 years of age or over' (DHSS, 1988, p.10). It has also been found that by far the most common reason given by mothers for giving up breastfeeding in the early weeks was 'insufficient milk' (Martin, 1978; Martin & Monk, 1982; DHSS, 1988; White et al., 1992), followed by 'painful breasts or nipples' and 'baby wouldn't suck/rejected the breast' etc. Medical practices, routines and advice have also been scrutinised for their effects on women attempting to breastfeed, and recommendations made to remove obstacles (e.g. DHSS, 1974; Culley et al., 1979; Lawrence, 1982; Martin & Monk, 1982; DHSS, rev. 1983; Fisher, 1985; Rajan, 1985; Rowe, 1985; Rundall, 1985; Jackson, 1990a).

But the purpose of such research is to inform strategies for increasing breastfeeding rates, given that evidence shows this method of feeding to be more healthy



for babies. Such strategies have centred on health education: informing potential parents of the superiority of breastfeeding and imparting to mothers sufficient knowledge and practical skill for them to be able to do it. Underlying such strategies is the traditional ideological view which identifies women with motherhood and assumes that a mother's over-riding desire is to serve the needs of her baby. Thus failure to breastfeed is treated as a matter of maternal ignorance, or irresponsibility: once mothers are aware of the benefits of breastfeeding they should want to do it, and once they have been given sufficient knowledge and skill they should be able to do it. Recognition of other obstacles beyond the mother's control extends only to the organisation of post-natal hospital care, and the influence of husbands. Therefore as perceptions of breastfeeding as a physiological process have changed, hospital routines have been modified. Also, since it has been found that the attitudes of husbands to breastfeeding are of crucial importance to women in making their decisions, health education on the superiority of breastfeeding is meant to extend to potential *parents*, not just mothers (DHSS, 1988).

### 2.2.2 The Mothers' Reaction to the Rise of Bottle-feeding

Whereas the stimulus for medical interest in reviving breastfeeding was the evidence of health problems resulting from artificial feeding, for mothers it was more a matter of asserting the cultural value of the role of mother and protecting it from erosion by medical control and commoditisation.

By the 1960s mothers who wanted to breastfeed were swimming against the tide. There was no one with appropriate knowledge and experience to help them learn, and expert advice offered bottle-feeding as the solution to any breastfeeding doubts or problems. Support in their everyday lives was lacking as breastfeeding was an unfamiliar and culturally unacceptable phenomenon in public. Breasts were now

primarily defined in terms of sexual attractiveness to men (Jelliffe & Jelliffe, 1978).

As a response a group of mothers in the United States formed La Leche League in 1956 (La Leche League International, rev. 1988), a self-help group for women who wanted to breastfeed. Today it is an international organisation which provides written materials, local support groups, and lay counsellors who are experienced breastfeeders, who undertake health education and whom mothers can consult for advice on overcoming problems. La Leche League has a presence in Britain, but better known here is the National Childbirth Trust (NCT) which was formed in 1956 (NCT, 1986), in the first instance to help women prepare for childbirth, but which has broadened its concerns to 'education for parenthood'. Again, the organisation is run by experienced mothers. There are ante-natal classes run by lay teachers, post-natal support groups, and lay breastfeeding counsellors. In 1966 the Trust formed a sub-section called the Breastfeeding Promotion Group. In 1985 it had 550 breastfeeding counsellors who counselled 25,014 parents postnatally (NCT, 1986a, p.6). Similar breastfeeding promotion and support groups have been formed in many other countries (e.g. Nursing Mothers Association of Australia).

Such organisations have a largely middle-class following, and the swing back to breastfeeding has been led by middle-class women. In general the ethos of such organisations is that a 'natural' life-style is the most healthy and should be supported against the encroachment of advanced technology - therefore such things as 'natural childbirth' and 'whole food' also meet with approval. In their support of breastfeeding such organisations have challenged the medical establishment in its assumptions and practices, and have also given support to women deviating from social norms by breastfeeding (Ladas, 1972). However, the identification of women with motherhood

has not been challenged. In fact it has been re-asserted as the means of fulfilment for women, with the experience of breastfeeding playing an important part in that fulfilment. The challenge to society's cultural hostility to breastfeeding has therefore been limited. Thus the emphasis has been on advising women on how to feed discreetly in public and campaigning for the provision of facilities for breastfeeding in private rather than asserting a right to feed openly anywhere. Also, women have been advised on how to continue meeting their husband's needs whilst breastfeeding rather than demanding his support (e.g. Kitzinger, rev. 1973).

The 'natural' approach of these groups re-asserts the importance of the mother only as the server of her baby's needs. Instead of mothers being the instrument for imposing on their babies the routines devised by medical experts based on 'scientific' assessment of babies' needs, the babies themselves are seen as the best judges of their needs, and mothers must respond sensitively, feeding on demand, sleeping with their babies and weaning from the breast only when the baby loses interest.

It must be said that some breastfeeding groups have taken a more extreme stance than others. For instance, La Leche League give support only for establishing or maintaining breastfeeding: bottle-feeding is not entertained as a solution. However, the NCT will support women who decide to give up breastfeeding, and counsellors are usually willing to be consulted for bottle-feeding problems also. La Leche League also puts more emphasis on 'baby-led weaning' than the NCT, with a general expectation that breastfeeding will continue beyond the first year. However, there has been some shifting of ground in response to feminism. For instance, such groups originally assumed the normality and desirability of mothers staying at home to devote themselves to their babies with the husband/father as the breadwinner. Today more recognition is

given to women returning to employment with advice on how to maintain breastfeeding in these circumstances.

Nevertheless, the approach remains baby-centred. Instead of being subject to the authority of medical experts, mothers are now subject to the demands of their babies.

The next chapter will show how the pro-breastfeeding movement's view of mothers as servers of their babies' needs is part of a cultural construction of motherhood which plays a key part in maintaining women's subordination to men in our society.

## **CHAPTER 3: A FEMINIST PERSPECTIVE ON WOMEN AND MOTHERS IN SOCIETY TODAY**

### **3.1 WOMEN'S POSITION IN SOCIETY**

This study will examine how women's experiences as they come to breastfeed their babies are socially structured so that male social dominance is not threatened by this particular aspect of female reproductive power. But first the general subordination of women in our society will be considered, to set the social context of women's lives as they enter motherhood and undertake to feed their babies for the first time.

#### **3.1.1 Cultural Definitions**

Women are human beings as much as men, but in our society they are culturally defined against a masculine standard of normality (Oakley, 1982). In a study (Rosenkrantz et al., 1968) where people were asked to rate personal qualities in terms of their relevance to the 'average female' and 'the average male', a stereotype of the typical male was produced:

someone who: is aggressive, independent, unemotional, or  
hides his emotions, is objective, easily influenced,  
dominant, likes maths and science: is not excitable in a  
minor crisis; is active, competitive, logical, worldly,  
skilled in business, direct, knows the ways of the world;  
is someone whose feelings are not easily hurt; is  
adventurous, makes decisions easily, never cries, acts as  
a leader; is self-confident; is not uncomfortable about  
being aggressive; is ambitious, able to separate feelings

from ideas; is not dependent, not conceited about his appearance; thinks men are superior to women, and talks freely about sex with men. (Fransella & Frost, 1977, pp.43-4)

In contrast the typical female emerged as:

someone who: does not use harsh language; is talkative, tactful, gentle; is aware of the feelings of others; is religious, interested in her own appearance, neat in habits, quiet; has a strong need for security, appreciates art and literature, and expresses tender feelings. (Fransella & Frost, 1977, p.43)

In a second study (Broverman et al. 1970) mental health clinicians were asked to complete the Rosenkrantz questionnaire, one group in terms of normal adult men, the second for normal adult women, and the third for 'a healthy, mature, socially competent person' (Oakley, 1982, p.64). Oakley sums up the findings:

Socially desirable masculine characteristics were seen as healthier for men than for women. Healthy women were more submissive, less aggressive, less competitive, more excitable, more easily hurt, more emotional, more conceited about their appearance and less objective than healthy men. (Oakley, 1982, pp.64-5)

A woman therefore is caught in a trap of double standards: 'to be considered mature and healthy, she must behave in ways that are socially undesirable and immature for a competent adult.' (ibid. p.65) On the other hand, if she behaves in culturally more

valued ways she risks having her femininity questioned.

Wallsgrave (1980) points out that not only are masculine characteristics more highly valued, but they are also associated with power. They mean that men are seen as being in control: of themselves, their thoughts and emotions, and of others. Feminine qualities, in contrast, are qualities of powerlessness and subordination of one's own needs and desires to those of others.

But above all, women are culturally defined as maternal. Women have their own sexuality and only women can be mothers in the sense that only women can bear and suckle a child, but the cultural construction of motherhood ensures that women's reproductive powers do not threaten the male-dominated social order. Historically a distinction has been made between the 'good' woman who has all the virtues which keep her submissive to the male social order, and the 'evil' woman who threatens that social order. As Oakley (1982) points out, the first mother in Christianity was Eve, the 'evil temptress', but it is Mary, 'the chaste and charitable Virgin' who

symbolises goodness, purity, gentleness and submission, and, beyond a simple representation of the nobility of motherhood, stands for the ideal woman. All women are potential mothers: mothers are good women and good women are mothers. Marian iconography expresses the totality of women's supposed instinctive, tender and asexual devotion to their children. (p.86)

Again, the cultural ideal adds up to a mother's lack of power. She is submissive, she has no sexual appetite except a desire to get children, and she puts the needs of others before her own.

### 3.1.2 Women's Social Roles

Women's social roles follow from their being identified with their reproductive role. This does not mean that women's social roles depend on their biology, but on cultural attitudes towards their procreative role. Motherhood is regarded as a woman's primary role, to which other roles (e.g. employment) are secondary. Ideologically the means to self-fulfilment and full adult maturity for women are through becoming mothers (Oakley, 1982).

In the cultural construction of motherhood, three roles are inextricably linked: wife, houseworker and childrearer (Fransella & Frost, 1977). It is logically possible for all three of these roles to be performed by different people, but in our culture they are seen as 'naturally' part of motherhood. With the removal of production from the home to the factory during the process of industrialization, domestic activities have been separated from the productive process (the world of paid work) and the public sphere of cultural activity. The work of housework and childcare has been assigned to the wife/mother, which she performs in the seclusion of the family home. This has a socially disadvantaging effect for women both in the world of paid employment and in the home. It is customary for women without child-care responsibilities to take paid employment, but the world of paid work makes little or no concession to the needs of the domestic sphere. Women may fit housework into their 'spare time', but they are expected ideally to give personal and continuous care to their babies and small children. The expected interruptions to careers because of the demands of child-care, and the assumption that women are primarily supported by male bread-winners earning a family wage, serve to curtail the opportunities and encouragement given by employees to women to pursue well-paid careers in their own right, and also have a dampening effect



on the career aspirations and expectations of women themselves and of significant others for them. As unpaid housewives women (together with their small children) are financially dependent on a male breadwinner. As Galbraith notes: 'in a society which sets store by pecuniary achievement, a natural authority resides with the person who earns the money...The household, in the established economies, is essentially a disguise for the exercise of male authority.' (Galbraith, 1973, pp.35-6)

### 3.2 BECOMING A MOTHER

Having looked at women's subordination in general, I shall now focus more closely on the context in which mothers take on the task of feeding their babies.

This can be considered under two headings: as an aspect of reproduction, and as part of the role of mother. As has been said, lactation is one of the physiological consequences of giving birth, and breastfeeding is the biologically provided means for sustaining the life and development of the new-born baby. Also, in our society mothers' first attempts to breastfeed are bound up in the management of childbirth, as part of their maternity care. Breastfeeding can therefore be regarded both biologically and by cultural definition as part of the reproductive process, and its management and how it is experienced will be affected by cultural controls on reproduction. But breastfeeding extends beyond the period of postpartum maternity care. It is something mothers have to assimilate into their everyday lives under their own management, as part of their mother-role. Women's situation and general experiences as mothers are therefore also relevant to how they will experience breastfeeding.

#### 3.2.1 Controlling Women as Reproducers

Oakley (1976a & 1980) has distinguished two ways in which male control over women's reproductive powers has been achieved historically: separation and

incorporation.

### Separation

When separation is the mode of control, knowledge, practice and control of the business of reproduction belong to women, but it is kept separate from the rest of society so that public cultural activity and social order will not be disrupted. Contact with evidence of women's reproductive powers is defined as polluting, or as a source of fear or disgust. Typically, therefore, women are subject to special regulations when they are menstruating, giving birth or lactating, which restrict and isolate them during these periods, although the precise form of regulation will vary between societies.

For instance, in the Jewish tradition there are prohibitions against a man having sexual intercourse with his wife while she is menstruating, and against her handling food (Oakley, 1976a, p.32). In some societies women must withdraw from village life completely and spend the period in a special menstrual hut. Among the Adivi of Southern India a woman must go to a special hut 200 yards away from the village to give birth and remain there for ninety days afterwards. 'A midwife is allowed to deliver the baby, but if anyone else touches the woman they become social outcasts and are banned from the village for three months.' (Oakley, 1976a, p.32) In the Christian tradition during the Middle Ages and beyond midwifery was seen by the Church as an unclean profession (Rich, 1977, p.134), and the custom of 'churaching' a woman at the end of her confinement was originally to purify her before her return to full social intercourse (Rushton, 1983, p.122). Although separation is a way of keeping women's reproductive powers under male control, it is a form which allows women to retain control over the actual practice, and an autonomous female knowledge passed on through generations of women. Women are therefore both the managers and the experts when

it comes to their own reproductive functions.

### Incorporation

When incorporation is the mode of control, women lose this autonomy and control. Knowledge and practice are under the control of members of the dominant group. Thus in western society, whereas giving birth was once of no interest to physicians (a male profession) but was left to women with the aid of a local 'wisewoman' or midwife, it is now a hospitalized event managed by a male-dominated medical profession. Doctors now make the decisions as to how women are to be managed as maternity 'cases', and doctors are also the authorities on other aspects of reproduction, e.g. pre-natal counselling, birth control, abortion, etc., and in most cases have a legal monopoly of control over the delivery of these services. Thus women's reproductive functions have become the subject of medical discourse: knowledge and management of them have become the business of a medical profession whose members are predominantly male, and whose authority is legitimated by 'science'.

### Breastfeeding

In our society today breastfeeding is 'separated' since sight of it causes embarrassment and even disgust. Breasts are defined primarily in terms of sexual attractiveness to men, and bearing a breast in front of men carries the connotation of sexual provocation. Breastfeeding also has cultural associations with other examples of passing body fluids (e.g. urination, defaecation, spitting) (Gaskin, 1987; Van Esterik, 1989), that is as unclean and contaminating, and therefore kept separate from cultural activity by rules of hygiene and norms of privacy.

However, 'separation' does not apply to the extent that women have their own autonomous knowledge and control over the process even though they have to

incorporate it into their everyday lives. Medical experts are the authorities on infant feeding, and this, together with the rise of bottle-feeding, has led to a lack of autonomous female knowledge of breastfeeding. The medicalisation of childbirth has also meant that first attempts to breastfeed are made under medical supervision. Therefore much of breastfeeding is 'incorporated', although medical control does not extend as far as with childbirth (and medical interest is not so great).

### 3.3 MEDICALISATION AND REPRODUCTION

What are the implications for women of reproduction now being the business of medical experts whose knowledge is based on 'science'?

Historically the rise of the medical profession is bound up with its espousal of science from about the end of the 18th century. Science developed as a method of rational enquiry: 'facts' were gathered and proved through observation and experimentation. The apparent objectivity of such knowledge gave it the status of absolute truth.

Legitimated by science, medicine has become a very powerful institution in western society. The medical profession is the authoritative source of knowledge on health matters, and it holds the monopoly on medical practice. It also has a high degree of autonomy: the State has some control over funding and organisation of services, but the profession controls its own production of knowledge, ethical standards and regulation of practice. Medicine has also become powerful in the social construction of reality through its power to define normality and deviance. Where the Church can label deviance 'sinful' and call for repentance, and the Law can label deviance 'criminal' and call for punishment or reparation, medicine can define deviance as illness which needs medical treatment to effect a cure (Freidson, 1970). Medicine has also expanded its

influence by bringing more and more aspects of people's lives into the medical sphere of influence ('medicalisation').

Although the medical profession has technical autonomy it is dependent on the State which has increasingly taken on responsibility for the funding and organisation of health care. The profession's autonomy ultimately, therefore, rests on its alliance with the State. Thus medicine is an official institution, helping to maintain the social order, and social policy and health policy are one (Oakley 1986e, p.256).

Functionalist sociologists have seen the medical profession's power and high status as a reflection of the functional importance of looking after the health needs of society's members (Haralambos & Holborn, rev. 1990, p.67). The guiding principles of medical practice have been seen as a reflection of a societal value-consensus, and medicine is therefore seen as benefiting society as a whole. But other sociologists, including feminists, have questioned the objectivity of medical 'science' and the neutrality of the medical profession.

Scientific knowledge, like any other form of knowledge, is socially produced, and is therefore subject to social influences. What is 'discovered' and how it is perceived and presented is a product of the social concerns of those involved in its discovery.

As to the profession of medicine, like any other profession it can be seen as serving the interests of its members. Parry & Parry (1976) for instance have seen professionalism as a market strategy. It is in doctors' interests to build up their sphere of influence, and the process of medicalisation of more and more areas of everyday life could be seen as a reflection of this process and not necessarily of benefit to the health of society's members.

But more than this, with medicine as an official institution in alliance with the

State, in a capitalist/patriarchal system, medicine and the organisation of health care will reflect and support the capitalist/patriarchal organisation of society, and can be viewed as contributing to the oppression of subordinate groups in such a society.

Illich (1977) condemns modern medicine outright as both physically and socially harmful (although he sees it as the product of over-industrialisation rather than capitalism). He distinguishes three levels of 'iatrogenesis': (1) clinical iatrogenesis (medically induced ill-health); (2) social iatrogenesis (when health care is organised in such a way that people are no longer able to look after their own health needs but are dependent on medical services); (3) cultural (or structural) iatrogenesis (when people's ability to face up to the inevitability of pain, suffering and death is undermined). He points out that medical jurisdiction constantly expands to cover every aspect of living - even healthy people become subject to 'preventive' medicine, monitored by screening health checks and educated with advice on healthy life-styles. The development of medical knowledge as a 'science' based on objective logic, measurement, experimentation, etc., means that the human being in medical discourse is reduced to a body which functions like a machine rather than a whole person who is part of a set of social relationships, and the emphasis is on treating the part of the body which is perceived to be malfunctioning. In an advanced industrial society medical care is consumed like commodities, and people are reduced to passive consumers of medical care over whose production they have no control, and of which they have little understanding. According to Illich, medicine is:

...a package made up of chemicals, apparatus, buildings,  
and specialists, and delivered to the client...The patient is  
reduced to an object - his body - being repaired; he is no

longer a subject being helped to heal. (Illich, 1977, p.238)

Illich sees the solution in the elimination of modern medicine altogether, together with de-bureaucratisation and de-industrialisation, in order to give power and responsibility back to ordinary people.

Whilst much of Illich's criticism is compatible with a Marxist view, a Marxist analysis would see the ultimate cause of the problem as class exploitation rather than over-industrialisation, and would see the solution in the revolutionary over-throw of capitalism. Overall the organisation of health care is in a form compatible with the organisation of the capitalist economy, and its delivery also carries ideological messages (Navarro, 1976).

One of the requirements of capitalism is that workers remain under the control of the owners/controllers of the means of production rather than having autonomy - hence the hierarchical organisation of the production process and the fragmentation of knowledge and tasks. Similarly medical health care is organised hierarchically, with doctors (predominantly drawn from the upper and upper middle-classes and male) in over-all decision-making control, and ranks of junior doctors, nurses, auxiliary nurses, technicians, etc. to carry out the more routine tasks under the authority and direction of the doctors. At the bottom of the hierarchy is the patient who obeys orders and submits to treatments. Knowledge is fragmented into specialisms, and those in lower positions in the hierarchy are not expected to have much understanding of it or the processes in which they are involved.

In a capitalist system home and community production of goods and services must be replaced as far as possible by passive consumption of commodities which produce profits for the producers (Campbell, 1984). The consumer becomes dependent on an

impersonal, centralised production process, designed and controlled by experts with specialist knowledge. The health care system is itself a vast, profit-making enterprise with reliance on (constantly updated) medical technology, drugs, hospital buildings and equipment, etc. Patients become increasingly dependent on such resources rather than being able to care for themselves or rely on local community knowledge and care. Even knowledge of everyday living such as child-care, instead of being shared through community relationships of social equals and transmitted across generations, is increasingly dispensed in commodity packages put together by experts - through books, TV programmes, health education literature, etc.

These processes do not affect only women, of course, but they are discernible in the way women become mothers in our society. For instance, whereas giving birth was once managed by women in the community with the aid of lay midwives, it is now a medicalised, hospitalised event. For maternity care a woman is separated from her own social environment and supporters, and is tended in unfamiliar surroundings by strangers. Oakley (1981a) points out how the medical profession actively works to discredit the knowledge and advice of experienced women in the community as a source of information and guidance to the new or expectant mother. The division of labour is hierarchical (Roberts, 1981), with predominantly male doctors in overall decision-making control at the top and the mother at the bottom passively obeying instructions and submitting to treatments. The mother is not expected to have more than a limited understanding of the processes involved or to have relevant knowledge of her own to contribute to the management of her care. In medical discourse and practice the mother is reduced to a reproductive machine (Oakley 1986d, pp.75-6) which cannot be trusted to work properly without the attentions of the doctor-mechanic. 'Thus ante-natal care



is maintenance- and malfunction-spotting work.' (ibid., p.76) Ante-natal education in preparation for the birth covering relaxation techniques and explanations of obstetric techniques and technology are for the purpose of rendering the mother more compliant and efficient as a reproductive machine rather than to impart knowledge for her own use (Oakley, 1986e, pp.262-4). Expensive and sophisticated equipment and drugs are now an essential part of maternity care. Machines are increasingly used to monitor and control pregnancy and birth, which Oakley (1986d) calls 'a merging of the pregnant female body with the high-powered technology of modern obstetrics.' (p.76) Martin (1989) argues that in medical discourse on birth, beyond the metaphor of 'body as machine and doctor as mechanic' (p.56) are analogies drawn from factory production. Thus labour is a production process: the uterus is the machine, the woman the labourer, the doctor is the supervisor or foreman of the labour process, and the baby is the product. But women are not active labourers in the process, but are controlled and treated according to exact specifications (p.19). In fact, the woman herself is often obliterated in medical discourse, and it is the doctor who produces, or extracts, the baby from a foetus receptacle (Oakley, 1980; Martin, 1989; Treichler, 1990).

In this thesis it will be shown how the organisation of health care affects breastfeeding - how it has served the medical profession to render women dependent on them for feeding advice, and the commercial interests of manufacturers to render them dependent on a commodity (Campbell, 1984). The iatrogenic effects of medical care on women's breastfeeding abilities will also be examined.

From the 1960s criticisms of the medical management of childbirth have grown, and there is now a recognised 'natural childbirth' movement. Contributions to this have come from 'consumers' (e.g. Arms, 1975) and 'consumer' groups (e.g. National

Childbirth Trust; Association for Improvements in Maternity Services), from feminist sources and from within the medical profession itself (e.g. the French obstetricians Leboyer and Odent). The result, according to Oakley (1986e) has been an 'alternative model of birth to the prevailing medical one' (p.238). The medical model aims to gain control over the birth process with standardised management in order to achieve a predictable, 'no risk' outcome. A 'successful' birth is therefore defined in terms of the production of a healthy baby. The critics have questioned the possibility of the 'no risk' birth, and have pointed out the iatrogenic effects of medicalisation, arguing that medical management has made giving birth more risky for most women. In the alternative model, 'a good birth is one achieved without drugs, without interventions, and in which, most of all, the mother retains control of herself, her body and her baby.' (Oakley, 1986e, p.238) Thus a successful birth includes a satisfying birth experience for the mother, and the 'subsequent incorporation of the baby into a network of thriving social relationships' (p.238). Compared to the more narrowly conceived medical model which ignores the mother's social circumstances and relationships, the alternative model recognises birth as a social event.

Some of the criticisms from the 'natural childbirth movement' have been taken on board by the medical profession and changes made in practice to humanise the process of giving birth, but the aim of medical, technological control remains. Overall then the experiences of a new mother immediately preceding and surrounding her taking on the feeding of her baby are of passive dependency, loss of social identity and loss of control.

### 3.4 THE MYTH OF SCIENTIFIC OBJECTIVITY

But medical control over reproduction is not the only way in which modern

medicine acts as an agent for control over women. In a patriarchal society medicine also contributes to the subordination of women through its power to define health and ill-health, normality and deviance, and through the ideological messages imparted through medical advice and the delivery of health care.

As has been said, the authority of the medical profession is legitimated through its basis in science. Scientific enquiry began to challenge the cultural dominance of the (male-controlled) Church in the 17th century, and from the beginning was concerned not only with understanding nature but also with controlling it. Women's cultural association with nature rendered them part of the subject to be studied and controlled. Indeed, nature itself was conceptualised as female. Thus the language of scientific writers was typically imperialistic and sexist: nature was seen as new territory to conquer and a female entity to be ravished of her secrets. Arnold & Faulkner (1985) quote from Francis Bacon 'the celebrated proponent of the new philosophy' in the 17th century, explaining the reasons for the new methodology:

men (and he meant *men*) were not on 'such familiar terms with nature that, in response to casual and perfunctory salutation, she would condescend to unveil for us her mysteries and bestow on us her blessings.' Rather, 'the secrets of nature reveal themselves more readily under the vexations of art than when they go their own ways'. Thus, Bacon appealed to the 'true sons of knowledge' to turn their 'united forces against the Nature of things, to storm and occupy her castles and strongholds'. (Arnold & Faulkner, 1985, p.27)

Ehrenreich & English (1979) quote Oliver Wendell Holmes, Sr., 'a regular doctor and early champion of scientific medicine' (p.69) as saying,

I liked to follow the workings of another mind through these minute, teasing investigations, to see a relentless observer get hold of Nature and squeeze her until the sweat broke out all over her and Sphincters loosened...

(p.69)

Pre-industrially the Church, as the major ideological influence, had, by associating women with their sexuality, defined them as a constant temptation to men, a distraction from a higher spiritual life (Ehrenreich & English, 1973 & 1979). Women were therefore to be controlled by men because of their moral inferiority. Scientific medicine also associated women with their reproductive functions, but now they were in need of protection and control because of their physical inferiority. In Victorian times upper and upper middle-class women (a potential source of high fees) were defined by doctors as totally dominated by their reproductive functions which from menarche to menopause and beyond could cause physical and emotional havoc, and which necessitated that they conserve their energies and try to maintain stability by avoiding both physical exertion and intellectual stimulation. On the other hand, the very real problems of working-class women (resulting from poverty and over-work) were not of concern to fee-charging doctors. Rather, these women were defined as a danger to the higher social classes, bringing germs into their homes as domestic servants and venereal disease into their marriages through prostitution. So, depending on social class, women were either inherently sick or a source of sickness (Ehrenreich & English, 1973).

Today the emphasis has switched to women's psychological weakness. Women

are seen as prone to emotional disturbance causing mental ill-health in themselves and posing a danger to those close to them (e.g. husbands) or those entrusted to their care (e.g. children) (Ehrenreich & English, 1979). By equating women with their reproductive role, two alternative explanations are offered: hormonal imbalance, or (from psychology) a disturbance in femininity (Oakley, 1986d). Thus, for instance, post-natal depression has been attributed to hormonal changes following giving birth or alternatively to a rejection of the feminine/motherhood role. Oakley (1980) argues that explanations for post-natal depression are sought in terms of women's biology and psyche because only women give birth. If women were seen first of all as people, then the momentous event of giving birth could be seen as a 'life event' which like other life events such as bereavement, surgery, retirement and unemployment, brings changes which call for a restructuring of meaning and which are therefore likely to lead to depression.

The explanation of a 'failure to achieve a mature femininity' has been used by psychologists to account for all sorts of difficulties such as painful menstrual periods, morning sickness and difficult births (Oakley, 1980 & 1986d). Yet Breen (1975) found that it was the women who scored higher on measures of conventional femininity who were more likely to experience difficulties giving birth, which suggests that the qualities culturally defined as feminine are not those which best equip women to cope with female processes such as giving birth.

Another way in which medical 'science' is less than objective is in the negative ways in which the workings of women's bodies are conceived in medical discourse. Thus, for instance, Martin (1989) shows how menstruation is described in terms of failed production (p.49) with negative words like 'degenerating', 'weakening' and

'deteriorating' (p.50). This follows from the assumption that implanting a fertilised egg is the proper goal of the menstrual cycle. Martin suggests alternative views - e.g. menstrual blood as a sign of womanhood (1990), or that if a woman is taking measures to avoid conception, menstrual blood could be viewed as the desired product of the cycle (1989).

### 3.5 THE 'NORMAL' WOMAN OF THE MEDICAL PARADIGM

Medical ideas about women and mothers, revealed for instance in medical textbooks and health education literature, add up to an image of dependence on male, or medical, protection and control.

In medical discourse a woman is normally heterosexual, and wants to marry and have children. She does not have a strong or independent sex drive of her own (Scully & Bart, 1978), but her sexual fulfilment rather lies in becoming pregnant and meeting her husband's sexual desire. When women are given advice on sexual difficulties the concern is mainly that their husbands should be kept happy (Oakley, 1981a). Similarly a woman is not supposed to want to have a baby independently of a husband - doctors are more likely to grant abortions to women who are unmarried and whose boyfriends are unwilling to marry them (Macintyre, 1976), and are less likely to refer single women for infertility treatment.

In fact, a mother is not supposed to have strong, independent desires of her own generally. She is assumed to be instinctively altruistic, gaining fulfilment in caring for others. Thus Oakley (1981a) found that mothers in ante-natal advice literature are assumed always to put the baby first before their own needs or desires.

However, mothers are not trusted with their children since they are also seen as ignorant and irresponsible. As the primary carers of children mothers are rarely credited

with their healthy development, but are blamed when things go wrong. For instance, they cannot be trusted to give their children oral medication in the correct doses, they are the cause of infant diarrhoea through contaminating milk formula with their fingers, they damage their babies by making formula feeds too strong, and they cause emotional problems through their faulty upbringing techniques (Howell, 1978; DHSS, 1978; Ehrenreich & English, 1979). Oakley (1981a) also found women depicted as childish and irresponsible in ante-natal advice literature - liable to forget to take their medication, and 'beset with distracting whims and foolish fancies' (p.82) such as moving house during pregnancy.

Attributing women's problems to their inherent weaknesses as women conveniently avoids having to acknowledge the way a woman's social circumstances may have been created externally. For instance, in pointing out women's faulty upbringing techniques, doctors have conveniently overlooked the part their advice may have played in forming that practice. Ehrenreich & English (1979) show how expert advice on child-rearing has changed rapidly during this century to create contradictions even within the same generation. Characterising moving house as an expectant mother's whim overlooks how little control she may have in the matter when she is financially dependent on her husband, when housing markets or Council house vacancies are unpredictable, or when the need for larger accommodation may be urgent with a growing family. With regard to ignorance and irresponsibility, Graham (1976) found that women who smoked in pregnancy were not ignorant of the arguments against it, but either had countervailing evidence of their own (e.g. personal experience of healthy babies born to smoking mothers) and therefore had a different assessment of the medical evidence, or they justified their smoking in terms of its helping them to cope with other responsibilities.

Women's smoking in pregnancy is therefore linked 'in systematic ways with aspects of their material and social position' (Oakley, 1989, p.311). Similarly, mothers might give their children sweets with long-term health risks to gain short-term relief from demanding children when they were having to cope with other responsibilities (Graham, 1984 & 1990). Characterising these mothers as ignorant or irresponsible does not take into account the way that they do actually cope with conflicting responsibilities and pressures. Similarly, health education about AIDS aimed at young women does not acknowledge the unequal power relationships between sexual partners which limit how far women can control for safety (Holland, Ramazanoglu and Scott, 1990; Holland, Ramazanoglu, Scott, Sharpe and Thomson, 1990).

Women are also seen as neurotic, prone to anxiety and depression. Thus in antenatal advice literature (Oakley, 1981a) women are told it is normal to feel anxious, moody or depressed. Treating these mental states as a physical result of being pregnant avoids having to acknowledge that being pregnant in our society may involve uncertainties or problems which could affect anyone's mood.

Altogether, then, within the medical paradigm women are reduced to dependence: the fulfilment of their desires lies in serving other people, but as decision-makers they are weak and irresponsible and therefore in need of protection and control. In areas of their lives where women have to make their own decisions (e.g. the everyday tasks of motherhood) failure to adopt healthy behaviour is seen as evidence of women's ignorance or irresponsibility, and the relationship between their behaviour and their social and material positions is thus overlooked. This has relevance to breastfeeding, since the main emphasis in encouraging its revival has been on informing women of its benefits and helping them with the practicalities without addressing the social context of



their feeding decisions. When Graham (1980) found mothers changing from breast to bottle-feeding soon after discharge from hospital, and subsequently introducing solid foods sooner than medically recommended, she argued that these behaviours could not be understood in isolation from the material circumstances and social relationships of the family as a whole. Mothers coping with problems in their babies were also faced with rival obligations and responsibilities to other members of the family, and so these behaviours were compromise strategies to reconcile the baby's needs with those of the mother and the rest of the family.

### 3.6 TAKING ON THE ROLE OF MOTHER

One of the characteristics of industrial society is the separation between the 'public' and 'private' spheres, by which 'nature' is made subject to 'culture'. The public sphere is the world of economic production and higher cultural achievement, dominated by men. Here relationships are impersonal, bureaucratic and competitive. The private sphere is the place for the satisfaction of 'natural' human needs, both physical and emotional, and here are relegated the personal relationships and emotional expressiveness which could threaten the public social order. As children are not fully socialised into the culture of society, they too pose a threat to the social order of the public sphere, and are also kept separate. Home-making, caring and much child-socialisation are assigned to women in the home which is seen as women's natural domain.

In pre-industrial societies there is no distinction between domestic life and productive work. The division of labour between the sexes can take various forms, but women are integrated into the production process and their labour is an essential part of it. For instance, in pre-industrial Britain the bulk of the population were engaged in agriculture and textiles. The family was the unit of production and work centred around

the home. The 'family' consisted not only of father, mother and their children, but could also include apprentices and household servants who were children and young people of both sexes. All these family members contributed to the family's production, including the children from an early age (Oakley, 1976b). Women took part in agricultural and textile production themselves and trained and organised the work of their daughters and servants. In addition they were responsible for much production for home consumption such as baking, brewing, making clothes, soap, candles, medicines, etc. The functions of education, health-care, welfare and protection were also integrated into family life. A woman's labour was too valuable for her to devote herself full-time to baby-care and housework, much of which was done by the baby's older siblings and young female servants. The knowledge and skills that women needed were passed down from mother to daughter, with girls gaining their own practical experience through their integration in the household workforce (Ehrenreich & English, 1979). By the time a woman became a wife and mother she was fully equipped with the knowledge and skills necessary to take on the work expected of her. Women were kept subject to the male social order, not through economic weakness, but through the ideology of the Church which defined them as morally inferior to men, and through the law which made all family members subject to the authority of the father as the head of the household (Ehrenreich & English, 1979).

With industrialisation the factory replaced the home as the place of economic production. Although at first whole families went to work in the factories, the system evolved so that workers were employed as individuals and each was paid an individual wage. Ideologically the home became idealised as a place of refuge from the coldness of the impersonal, rational and competitive relationships in the productive sphere

(Ehrenreich & English, 1979). At home one could be expressive, and enjoy loving and caring relationships. Legislation was passed restricting the employment of women and children whose place was seen as in the home dependent on the husband/father's wage. There was a new ideological conception of women - the bourgeois wife whose husband could afford to keep her in idleness at home, devoted to bearing children and providing home comforts but with servants to do the actual work. However, such idleness was beyond the means of working-class women who had to keep working but whose employment opportunities were now limited by legislation and ideological conceptions of women being financially supported by men.

However, by the end of the 19th century the ideal of full-time housewifery was coming within the reach of working-class mothers, and for middle-class women some respectable female professions had opened up (e.g. teaching, nursing, office-work), but only for the unmarried. As servants became scarcer between the World Wars middle-class women joined their working-class sisters as domestic labourers, solely responsible for housework and child-care in the isolation of their own homes (Dally, 1982).

In this century there have been important reforms aimed at giving women social equality with men, e.g. voting rights, removal of many of the restrictions on women's employment, equal pay legislation and policies of 'equal opportunities'. However, culturally women are still held primarily responsible for child-care and housework, and the wife/mother who also works outside the home carries a double work burden. Women are no longer expected to give up employment on marriage, but with little child-care provision in this country most women's employment is interrupted by having children, and women are thereby disadvantaged in the labour market. Ideologically, though, mothering is supposed to be the means to a woman's self-fulfilment, with paid

employment of secondary importance. But through the way motherhood is instituted today women are alienated from the full realisation of the potential for self-fulfilment through the giving and sustaining of life.

Giving birth is a momentous physical event and would involve a change of social status in any society, but the separation of the public and private spheres means that becoming a mother, especially for the first time, is a major change in a woman's life. Oakley (1980) likens it to other life-events such as retirement, bereavement or unemployment which bring change which 'challenges the individual's assumptive world' and which can lead to depression if new meanings cannot be found (p.230). Apart from the changes in work and responsibilities involved in taking on the new role of mother, there is also the loss, for most women of indeterminate duration, of outside employment. Giving up a job to stay at home involves loss of outside interest, loss of social contact, loss of social status and loss of earnings. The new mother is now completely financially dependent and must adjust to a reduction in household income. She has also lost her identity in the public world of work. Although motherhood is ideologically glorified, the actual work involved is culturally undervalued and not even recognised as work. The woman is reduced to the wife of her husband and the mother of her child, and may well feel a loss of status and recognition as a person in her own right.

Women could well therefore come to motherhood with ambivalent feelings, and these could well be exacerbated by the growing emphasis in recent years on individualism and consumerism (which conflict with the ideal of self-denial), and with feminist questioning of the myth of motherhood. Women are aware that motherhood involves draw-backs (Wearing, 1984), but the cultural glorification of motherhood meant that they could at least feel that the ideal was culturally valued and worth striving for,

but now motherhood has lost some of its image as the means to women's self-fulfilment. Social equality for women has been interpreted in terms of masculine criteria. Today therefore women are subject to two incompatible cultural constructions of self-fulfilment: that as a woman through motherhood, and that as a 'person' through pursuits previously thought the preserve of men. The attainment of social equality is seen in terms of equal opportunities to achieve success in the masculine public world. Yet, despite such measures as policies of non-discrimination and maternity leave, childcare and housework remain primarily the mother's responsibility with little child-care provision to help mothers. Also, today's emphasis on sexual freedom and the importance of sexual intercourse for personal satisfaction for women as well as men, conflicts with the sexless image of the ideal mother whose satisfaction is found in having babies and tending to their needs. Giving birth and breastfeeding are not culturally defined as sexual experiences, and motherhood is seen as incompatible with the fulfilment of sexual desire (Kitzinger, 1978).

The new ideal of the 'superwoman' who manages both motherhood and a public career therefore places additional burdens on the middle-class woman in particular. She is supposed to be able to meet the demands of two completely separate jobs which are basically incompatible. She is the primary carer of her children, and yet their needs and any other domestic concerns must not intrude into her public life. Also she must be able to adjust to the impersonal, competitive social relations of the public world, and provide an expressive, caring ambience at home. Therefore, whether a woman decides to interrupt her career for full-time motherhood, or combine the two, she is culturally in a no-win situation. As a career woman she may feel guilty about trying to 'have her cake and eat it.' She may worry about 'depriving' her children and feel a failure as a

mother. As a full-time mother she may worry about her missed opportunities and feel a failure as a person. (Bernard, 1975a & b)

The way the medicalisation of childbirth results in a woman's experience of the actual process of birth being one of being controlled by doctors and machines has already been dealt with. After the birth and return home from hospital women begin their new careers as child-carers and child-rearers. However, unlike women in pre-industrial societies, new mothers come to motherhood lacking relevant knowledge and experience of babies (Leach, 1979). The smallness of today's nuclear family means that children do not grow up helping with, or at least witnessing, the care of younger siblings, and the insularity of the nuclear family curtails experience with other families' babies. Also, when babies and children are separated from mainstream public life they are not easily observable. Neither is knowledge for parenthood taught much in the formal education system which gives priority to academic courses and to equipping future workers with relevant skills and knowledge. But the ideological belief in 'mother's instinct' makes a new mother's feelings of inadequacy into a personal failure, and the idealisation of motherhood means that she fails to live up to that ideal.

Professional experts are now the authoritative sources of knowledge and advice on baby- and child-care, but this advice is dispensed impersonally via written materials, films, etc., or verbally by health professionals who are strangers. Such advice is therefore generalised rather than given in the context of each woman's individual circumstances and concerns. Also, expert advice changes rapidly (Ehrenreich & English, 1979), and this, together with the variety of personnel and sources the mother comes into contact with, leads to mothers receiving contradictory advice. At the same time, the 'discoveries' of medical, psychological and educational specialists have made

the mothering of children more complex. Nowadays not only does the child's physical health depend on the mother's care, but so also does its psychological well-being and intellectual development (Ehrenreich & English, 1979).

Useful help and advice can often come from experienced women, especially a new mother's own mother (Oakley, 1981c), but the insularity of the nuclear family does put barriers against the sharing of knowledge and help, and changes in life-styles and expert advice can make the knowledge of the older generation seem out-of-date. However, studies of traditional, close-knit working-class communities have shown close co-operation between female relatives especially mothers and daughters (e.g. Young & Willmott, 1957), and female networks to be more influential than medical advice (McKinlay, 1973). But the growth of the 'privatised' working-class life-style (Goldthorpe & Lockwood et al., 1969) works against the maintenance of these close female ties.

On the other hand, mothers often form peer-group networks amongst their neighbours for social contact and support (e.g. Lopata, 1971; Willmott & Young, 1960). This is particularly associated with middle-class women. There are also the more formal lay organisations such as the National Childbirth Trust and La Leche League which offer breastfeeding counselling and post-natal support groups. Both these organisations were founded and continue to be run by experienced mothers, but their following is mainly middle-class.

With today's privatised life-style and companionate marriage, the husband is ideologically a mother's closest companion, and it is now ideologically acceptable for fathers to take a direct interest in their babies and children and to be involved in their care. Thus husbands are a source of much help and support to mothers, but they are

also required to earn a wage on which the family depends, and so they must be absent from home for long periods, with no concessions made by employers to the problems of parenting which are seen as primarily the mother's responsibility. Also, the family's dependence on the father's wage-earning capacity means that his fitness to fulfil this role must be maintained. Mothers may well feel there is a limit to the demands they can make on their husbands for help, e.g. the husband's need for sleep will take priority over their own. Husbands can therefore be an additional burden of responsibility in that it is part of the housewife/mother's role to look after his needs so that he can return to work laundered, fed, rested and emotionally sustained (Oakley, 1981a).

The separation of the public and private spheres is maintained by the hostility of the environment to babies and children in public places. Even in places where mothers must go to fulfil their housewife/mother role (e.g. shops, doctor's surgeries, public transport) there are problems such as lack of access for prams or facilities for changing nappies (Leach, 1979). The survey of the Joint Breastfeeding Initiative<sup>2</sup> found four out of ten people objecting to breastfeeding in public places (Midwives Chronicle, 1990), and yet seldom are facilities provided for feeding in private.

Altogether, coping with motherhood in western society today means coping with a situation shot through with cultural contradictions. For instance, pregnancy and birth are seen as healthy and natural, but also as dangerous and requiring medical management. Women are socialised to want to be mothers, but they are not prepared with the relevant knowledge and experience. Caring for a baby depends on 'mother's instinct', and yet professional experts are the authorities on proper baby-care. Being a wife and mother is assumed to be the highest goal a woman can achieve, and yet the

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<sup>2</sup>A combined effort by health professionals and lay organisations to encourage breastfeeding.



mother/housewife role has low social status and her work is undervalued and not even recognised as work. Caring and rearing the next generation is important and responsible work, and yet she is in a powerless economic position. Part of the cultural ideal of femininity is a child-like dependence, with doctors and husbands making important decisions for women, and yet a mother must be able to care for her children independently, making life and death decisions for them. She is in a position of authority over her children, but men have power and authority over her. Physically she is in a powerful position over helpless and dependent babies and children, and yet she must be always available to them, putting their needs before her own, and no matter how emotionally undisciplined and demanding they are, she must remain calm and patient (Wearing, 1984). In the day-to-day experience of motherhood, babies' demands are incompatible with housework and the duties of a wife: babies create mess, disrupt routines and demand attention at awkward times. In addition, there are conflicting ideas about how to care for babies, e.g. does meeting the babies' needs properly mean responding to every cry, or would that be 'spoiling' the baby?

Nevertheless, there is evidence that women do derive much personal satisfaction from their children (e.g. Oakley, 1981c). The first few months are characteristically a time when a mother is completely absorbed by her baby and its needs (Kitzinger, 1978; Rossiter, 1988), but it is an experience of heavy responsibility and uncertainty, especially with the first baby (Graham, 1979, pp.176-178). Studies of women's subjective experiences of motherhood have shown as endemic such feelings as anxiety, inadequacy, guilt, loneliness, failure and depression (e.g. Oakley, 1980 & 1981c; Rossiter, 1988).

### 3.7 CONCLUSION

Altogether the circumstances of motherhood work to diminish a woman's sense of achievement in experiences which are uniquely female. Firstly, male-dominated medical control over the physical act of giving birth undermine a sense of female achievement in the act of giving birth which only women are biologically equipped to do. Then, through the way motherhood is socially constructed and undervalued, with women's consequent dependence and uncertainty, women are again hindered from feeling successful, and from asserting themselves, in the role which has been culturally assigned to them. Thus, despite men's dependence on women in the important business of bearing and nurturing children, male dominance is not challenged.

In what follows, this process of maintaining male control will be examined with regard to breastfeeding in particular, both as an aspect of women's physical reproductive powers, and of the social role of motherhood.

## **CHAPTER 4: BREASTFEEDING: TWO OPPOSING MODELS**

Like the largely consumer-led 'natural childbirth' movement which has criticised medical management of childbirth, a similar trend in the movement to revive breastfeeding has been inspired by ideas of a rediscovery of the 'natural' way to feed babies (Cable & Rothenberger, 1984.), and has also criticised medical ideas and practices, seeing them as a cause of breastfeeding difficulties. I shall therefore distinguish between the medical approach (which I shall call the 'medical model'), and the 'natural' approach of the critics (which I shall call the 'natural ideal') which in many ways is superseding the medical model. Although for the sake of contrast I shall be presenting them as polarised views, in practice most people's beliefs and practices are a mixture. Also, the polarity is not a clear medical/consumer divide since some of the 'natural' criticisms have come from within the ranks of the medical profession (e.g. Jelliffe & Jelliffe, 1978; Stanway & Stanway, rev. 1983), and the ideas of the 'natural ideal' are increasingly being adopted in medical advice and practice, whilst lay knowledge still often includes assumptions which reflect medical model type ideas.

### **4.1 THE MEDICAL MODEL AND THE NATURAL IDEAL**

The medical approach to infant feeding, which has been criticised for hindering breastfeeding, can be seen as the product of the general medical aim of gaining control over human bodily processes through such means as objective measurement and standardisation of procedures. Thus infant feeding was a matter of following the correct rules, e.g. feeds were to be at three or four-hour intervals, and were to last no longer than twenty minutes (10 minutes at each breast). This is what I call the 'medical model' whereas the 'natural ideal' of its critics emphasises trusting in 'natural' processes, and

the unity of mother and baby. It goes beyond explaining breastfeeding in terms of mathematical calculations of chemical substances, and sees it as the basis of a continuing biological unity of mother and baby after birth. For instance, Jelliffe & Jelliffe (1978) regard the human new-born as an "'extero-gestate" or external foetus' for about the first nine months after birth:

During this time, he is completely dependent on the mother for protection and warmth, and her breasts function nutritionally as an external placenta. (p.4)

Similarly, Kitzinger (1978) refers to the first few months after birth as 'the fourth trimester of pregnancy'. By way of illustration both sources present images of traditional cultural practices in pre-industrial societies where mothers are in constant contact with their babies: having a time of seclusion alone with the new-born immediately after birth, then carrying the infant around on their bodies constantly when they return to their everyday duties and sleeping with it at night. In these circumstances breastfeeding is frequent and sporadic, in response to the demands of the infant and without disrupting the mother's everyday work. Knowledge of breastfeeding and baby-care has been culturally transmitted throughout the new mother's childhood, and she has experienced females on hand to consult should problems arise. Often one particular woman, a 'doula' (Raphael, 1969, referred to in Jelliffe & Jelliffe, 1978, p.175), gives the new mother constant care and assistance after the birth. The image is one of cultural unity: the learning and practice of mothering are integrated with the other aspects of everyday life.

Although both Jelliffe & Jelliffe (1978) and Kitzinger (1978) acknowledge the wide variation in cultural practice that actually exists even in traditional and pre-

industrial societies, this image represents a 'natural' ideal, whereby both baby and mother receive the maximum benefits conferred by nature, in a biological interaction. The baby receives nourishment perfectly adapted to its particular developing needs, together with immunological protection. The amount of milk made and consumed matches the amount needed because the baby controls its own intake and it is the baby's sucking which stimulates milk manufacture. For the mother, early stimulation of the breasts aids uterine involution through hormonal action, and prolonged and frequent suckling suppresses ovulation thus providing a natural method of birth spacing. Also, the intimate body contact between the breastfeeding couple encourages emotional attachment or 'bonding', which helps to ensure the mother's devotion to her baby's needs, brings emotional satisfaction to both mother and baby, and encourages social interaction between them which is important for the baby's social development.

## 4.2 BREASTFEEDING 'FACTS'

Research over the past thirty years or so has both stimulated and been stimulated by the development of the natural ideal approach, and I shall now give a summary of the current knowledge by which changes in breastfeeding practice and advice are justified.

### 4.2.1 Physiology of Breastfeeding

During pregnancy 'colostrum' is produced in the breasts, and for the first few days after birth this is what the breastfeeding baby receives. It is a yellowish substance, described by Minchin (1985) as a 'concentrated milk' for a newborn baby whose kidneys have not yet fully adjusted to handling large volumes of fluid (p.23). It has a high concentration of anti-infective agents, allowing the baby to receive as much antibody protection as it will when the volume of milk increases (Minchin, 1985, p.23). Colostrum also has laxative properties (ibid.), and aids the evacuation of the meconium

(Fildes, 1986, p.81). Minchin also describes this substance as 'of a kind best designed to getting all systems working well' in the newborn baby (op.cit. p.23).

What is recognised as 'milk' does not 'come in' until, generally, two to four days after birth, although this can vary. Milk production is stimulated by prolactin, the levels of which in the mother's bloodstream rise steadily during pregnancy, but its action is inhibited by the hormones progesterone and oestrogen. After the placenta has been delivered, there is a decline in the levels of these hormones to the point when the action of prolactin is no longer inhibited. (RCM, 1988, p.7)

In the breast the milk is produced by glandular epithelial cells, and stored in small clusters of 'sac-like' spaces, called alveoli. Around each sac is a basket array of muscle (myo-epithelial) cells. When the baby sucks from the nipple, nervous impulses are carried to the posterior pituitary and cause release of oxytocin into the bloodstream. This causes the myo-epithelial cells to contract, so that the milk is released into the 'ampullae' or lactiferous sinuses which lie behind the nipple, from which the baby removes the milk by rhythmical pressure by its tongue. This release of milk into the lactiferous sinuses is called the 'let-down' reflex, and is often felt by mothers as a tingling sensation in the breasts, and may sometimes be painful, especially in the first few days of breastfeeding. On the other hand, the mother may not feel the let-down reflex action at all. As the oxytocin acts on both breasts and the let-down reflex may be strong enough to expel milk without the baby's sucking action, there may be leaking from the breast not being suckled. The oxytocin also causes the uterus to contract in the first few days after the birth, which may cause the mother to feel 'after-pains', especially with second and subsequent babies. (RCM, 1988, pp.7-8)

The baby's sucking also stimulates the release of prolactin from the anterior

pituitary for continued milk production. If the nipple is not stimulated by such action, milk production ceases, usually within a few days. The continuing supply of milk therefore depends on the nipples being milked. In the first few days after the milk has come in, production does not match the amount taken by the baby, and so it is usual for breasts to feel over-full for a while (engorged), the discomfort of which is exacerbated by increased blood and tissue fluid in the breasts when the milk first comes in (Helsing & King, 1982, p.27). However, after this initial period the production of milk is in response to the sucking stimulation of the nipple, and is a matter of supply adjusting to demand.

High levels of prolactin in the bloodstream inhibit ovulation, and so lactating women usually experience an interval when they do not menstruate and they are infertile. How long this period lasts is variable, and is affected by levels of prolactin, how often the baby suckles, and the mother's state of nourishment and body weight (Jelliffe and Jelliffe, 1978).

It is recognised that there are psychological and emotional aspects to breastfeeding. For instance, oxytocin may be released and cause a let-down of milk without any actual nipple stimulation, but through a conditioned reflex, being stimulated by, for instance, hearing the baby cry, or thinking about breastfeeding. Milk may then leak from the breasts (Helsing & King, 1982, p.32) It is also widely accepted that the let-down reflex can be inhibited by anxiety or strong emotions in the mother. Jelliffe & Jelliffe (1978) explain that this is because adrenalin is released 'causing constriction of blood vessels around the alveoli, with decreased opportunity for circulating oxytocin to reach their target organ, the basket-like myoepithelial cells surrounding the alveoli.' (p.22). Helsing & King (1982) give this explanation as 'possibly' how it happens (p.33),

although no doubt is expressed that such emotional inhibition of the let-down reflex can occur and they cite examples from personal experience of milk therefore apparently 'drying up' (p.33). However, the Royal College of Midwives' booklet (1988) states: 'There is no evidence that the unconditioned reflex can be inhibited by anxiety.' (p.7) Yet this type of inhibition is often regarded as a major cause of breastfeeding failure, e.g.

Lactation has been termed a 'confidence trick', and failure in healthy well-nourished women with normal full-term babies is most frequently due to the 'anxiety-nursing-failure cycle', based on emotional interference with the let-down reflex. In westernized communities, the basic anxiety is related to lack of knowledge and social support, to the realization that alternatives are feasible and available, and to competing professional and social pursuits for women during which breast-feeding may be culturally unusual or logistically impossible...In other cultures, fear of bewitchment and of ultra-human forces can be responsible... (Jelliffe & Jelliffe, 1978, pp.22-3)

It has also been recognised that chronic anxiety in the mother can affect the actual production of milk (e.g. Jelliffe & Jelliffe, 1978; Helsing & King, 1982), but 'the effects are not so immediately obvious and we know less about it.' (Helsing & King, 1982, p.32)

The composition of human milk is not constant. It varies during the feed, during the day, from woman to woman and with the age of the baby. The first milk the baby



draws from the breast when it feeds is the 'fore' milk, followed by the 'hind' milk which is richer in fat and higher in energy. The concentration of fat in the milk is at its lowest in the early hours of the morning. During the course of lactation the most rapid changes take place in the first week after birth when there is a change from colostrum to 'milk' (DHSS, rev. 1983). A number of factors can vary the milk between women, such as diet, state of health, and exposure to infection.

#### 4.2.2 The Superiority of Breastfeeding

Today breastfeeding is recognised as superior to artificial feeding for babies for the following main reasons.

1. No artificial substitute has been devised which is as suited to the nutritional needs of the developing baby (Ebrahim, 1990).
2. Breast milk has immunity-conferring properties, protecting the baby against diarrhoea and other infectious diseases (e.g. measles) (Stanway & Stanway, rev. 1983; Cable & Rothenberger, 1984; Ebrahim, 1990; Howie et al., 1990).
3. Breast milk protects against the development of allergies (Jelliffe & Jelliffe, 1977; Kitzinger, 1979; Stanway & Stanway, rev. 1983; Cable & Rothenberger, 1984).
4. Breast milk does not carry the risk of bacterial contamination inherent in artificial substitutes, whether through contamination of the food itself or in the preparation process or through insufficient cleaning of bottles and teats (Palmer, 1988).
5. Breastfeeding is seen as important for the 'bonding' of mother and baby. Bonding is emotional attachment between mother and baby, thought necessary to ensure the mother's commitment to providing adequate care and the sort of mother-baby interaction necessary for the baby's early social development and future mental health (Jelliffe & Jelliffe, 1977; Blumen, 1980; Stanway & Stanway, rev. 1983; Ebrahim, 1990).

6. In communities where women do not have access to reliable methods of contraception, breastfeeding provides a natural method of birth spacing which, it is thought, has benefits for the health of both the mother and her babies (Knodel, 1977; Jelliffe & Jelliffe, 1977; Cable & Rothenberger, 1984).

#### 4.3 CRITICISMS OF THE MEDICAL APPROACH

I shall now outline how, from the perspective of the 'natural ideal' and in the light of today's knowledge, advice and routines established by the medical profession in this century are criticised for having obstructed breastfeeding. As far as the situation today is concerned, the medical model below is overdrawn since changes have been and are being made to accommodate the new ideas. Yet much of the medical model approach survives in hospital practice and health professionals' attitudes, and also in the lay advice of experienced mothers, leading to a conflict of ideas. Similarly the 'natural ideal' criticisms are given in their most extreme form.

1. Hospitalisation of childbirth has meant that a new mother begins breastfeeding in a strange, impersonal environment, subject to unfamiliar routines, and separated from her closest emotional supporters - a situation which is likely to interfere with the mother's self-confidence and lead to tension. Yet tension and anxiety can inhibit the let-down reflex, making it seem that the mother is failing to produce milk, and leading to frustration for the baby (Kitzinger, 1979; Palmer, 1988).

2. Hospitalisation has been associated with increased medical intervention in childbirth, making it more likely that the mother will have to recover from the injuries of such intervention (e.g. episiotomies, use of forceps, Caesarean sections). Pain or physical discomforts are again inimical to relaxation and self-confidence, and are debilitating at

a time when the mother is learning a new physical skill (Haire, 1978; Jelliffe & Jelliffe, 1978; Oakley, 1986b).

3. Increased use of drugs in labour, associated with hospitalised birth, leads to drowsiness in either mother or baby or both after the birth, impairing their abilities to learn the new process of breastfeeding (Kitzinger, 1979).

4. Organising hospitalised post-natal care around ideas of hygiene control and efficiency led to such practices as the routine separation of mother and baby at birth, mothers being cared for in a post-natal ward, and babies in a nursery possibly even by different nurses. Babies would be brought to their mothers for brief feeding intervals only. Today it is said that there is a sensitive period immediately after birth which is important for bonding. In any case, separating mothers from their babies is not going to aid the new mother in getting used to handling her baby, or build up her self-confidence (Kitzinger, 1979; Greasley, 1986).

5. Separation of mother and baby at birth, and adherence to set times for feeding throughout the day, meant that the first breastfeed would be delayed for several hours: perhaps as much as twelve hours as babies were not fed at night (La Leche League International, rev.1988). Today it is known that the baby's rooting reflex (opening its mouth wide and moving its head in search of the nipple) is strongest immediately after birth, and that delaying the first breastfeed impairs the chances of the baby learning how to latch on to the breast, especially if the baby is given other substances in the mean time through a rubber teat which could accustom the baby to a different sucking action (Minchin, 1985).

6. Observation of artificially fed babies had shown that a baby could finish its feed within twenty minutes, and that it took about four hours to digest. These then became

the rules of timing and duration of feeds, which were applied to breastfeeding (Clayton et al., 1979 & 1980). Hospital feeding times were on a rigid four-hour schedule (three-hour for small babies), with ten minutes at each breast. Today it is acknowledged that human milk is so different from artificial foods that, while these rules may be appropriate for bottle-feeding, they should not be applied to breastfeeding. Human milk is digested more easily and quickly than formula, and its composition is more like that of species which feed their offspring often than those which give long feeds at long intervals (Jelliffe & Jelliffe, 1978). Also, the consumption of human milk cannot be measured and controlled like formula. The consistency varies through the feed, through the day, and from day to day. Therefore, in light of the fact that one cannot tell the volume and concentration of milk taken at each feed, it is now felt that babies themselves should control their intake by being allowed to stay on the breast until they come off of their own accord, and by being fed 'on demand' i.e. being offered the breast whenever they appear hungry (signs of readiness to feed being crying or, in the young baby, the rooting reflex). Fears about over-feeding are now met with the maxim: 'You cannot over-feed a breastfed baby.' (Hall, 1975; Greasley, 1986; Palmer, 1988)

The demand and supply principle in the body's manufacture of milk is another reason for babies being fed on demand. Frequent suckling will encourage the milk to 'come in' sooner. After the first few days following the milk coming in, milk production will match the baby's demands. If there are fears that not enough is being produced, it is now advised that the baby be encouraged to suckle more often to stimulate production. A baby who is fed on a rigid schedule could well become hungry and distressed during the interval, wear itself out with crying, and then be too exhausted to feed properly at the next scheduled feed.

On the other hand, when the milk first comes in, it is usual for the breasts to feel over-full with excess milk. Frequent suckling prevents so large a build-up of milk and so helps to relieve engorgement (Salariya et al., 1979; Greasley, 1986). Not only does this relieve discomfort, but it also helps to prevent the ducts becoming blocked and therefore protects against breast infections and 'milk fever' (Stanway & Stanway, rev. 1983). Also, if the breasts are allowed to become badly engorged, the nipple protrudes less making it more difficult for the baby to latch on.

7. It had been observed that when bottle-fed babies finished their feeds, if they continued to suck on an empty bottle they were liable to gulp air and it was thought this made them windy. Ignorance of the physiology of the breast and human milk production led to the assumption that if a baby fed for more than ten minutes at each breast, the breast would be empty and it would be swallowing air. Today it is known that when milk is removed from the breast it does not leave an air space, and that the breast is never completely emptied anyway because the baby's sucking stimulates fresh milk manufacture. Suckling for more than ten minutes on a breast will not, therefore, lead to wind.

8. The medical view on caring for nipples was that the initiation of breastfeeding would inevitably lead to sore nipples if special precautions were not observed, and fair skinned women were particularly vulnerable (Palmer, 1988; RCM, 1988). The advice was to introduce feeding gradually, for instance, for one minute on each breast at each feed on the first day, two on the second, three on the third, five on the fourth, seven on the fifth and ten on the sixth. Sometimes hospitals allowed feeding from only one breast at a feed at first. Nowadays soreness in the first few days is seen as minor, normally clearing up in a few days without any need for special precautions, and skin colouring

is not seen as significant. Soreness which does become a problem is seen as the result of faulty latching on, and, again, medical practices based on bottle-feeding are blamed. For instance, a mother might be given her baby to feed in a position suitable for feeding from a bottle (sideways) rather than *en face* (Palmer, 1988, p.27), so that the nipple is pulled unevenly. Also, the sucking action from a rubber teat is different from a nipple, and medical professionals are blamed for not recognising this and therefore not being able to diagnose incorrect latching on. Not only does restricting time spent suckling in the first few days not prevent sore nipples, but it also carries risks for the successful establishment of breastfeeding for the reasons given in 6. when restriction of feeds to scheduled times was being discussed. On the other hand, if nipples should become sore, feeding often will mean that the baby sucks less hard at each feed because it is not so desperately hungry.

9. To protect against developing sore nipples mothers were advised to prepare during pregnancy by hardening them with scrubbing and alcohol. For hygiene they were advised to wash their nipples with soap before and after each feed. Today it is recognised that protective oils are secreted around the nipple, and that such treatments would have a drying effect, making the nipples more prone to soreness and cracking and therefore infection (Kitzinger, 1979; Greasley, 1986; Palmer, 1988).

10. Attempting to exert control and measurability over breastfeeding led to the introduction in hospitals of test-weighing. This refers to weighing a baby before and after a feed, the difference in the two weights being taken as a measure of how much the baby has consumed and, therefore, of how much milk the mother is producing. This is now seen as an unnecessary source of anxiety to the mother (who feels she is being tested) which could lead to inhibition of the let-down reflex resulting in a poor test result

and the subsequent diagnosis of insufficient milk and supplementation with formula. It is also not seen as a particularly accurate guide to how much milk the baby is obtaining, since the baby's intake will vary at different feeds (Kitzinger, 1979). Nowadays test-weighing is not recommended except when there are serious doubts about the amount a baby is obtaining, and then it should be done over a twenty-four hour period to see the total consumed in a day of feeding. But if a mother's milk supply is thought insufficient, the advice nowadays is to encourage the baby to feed more in order to stimulate production.

11. It is now recognised that there can also be pitfalls in weighing babies to monitor their growth. Setting an average weekly gain as a target can be misleading since babies grow in spurts rather than at a steady rate, and it is now thought that weight gains should be judged over a longer period (Rowe, 1985; Palmer, 1988). Also, hospitals have been blamed for resorting to supplements too readily in their enthusiasm to see babies re-gain their birth weight before leaving hospital. Again, it is now said that if a baby's weight gain is considered slow, the first response should be to encourage more suckling to stimulate milk production, and give attention to the mother's needs for nourishment, rest and reassurance.

12. Although fears about colostrum actually being a bad substance for babies have not been a feature of medical opinion this century, nevertheless colostrum has not been particularly valued and was not seen as proper food or drink. Consequently hospitals have seen fit to supplement with formula, glucose or water until the milk came in. Nowadays it is said that colostrum supplies all the nutrients and fluid needed by the baby in the first few days, and it is the most suitable feed. It is also valued for its anti-infective properties. Supplementing with other substances in the first few days again

risks the difficulties associated with lack of nipple stimulation to encourage the milk to come in, and the baby becoming accustomed to sucking from a rubber teat (Palmer, 1988).

13. Hospitals have also been criticised for using breast shields in cases of feeding difficulties such as sore nipples or non-protruding nipples. According to the natural ideal, shields should not be necessary as such problems are more appropriately dealt with by correcting the baby's latch and avoiding engorgement. It is said that the danger in using breast shields is that the baby does not learn the correct way to latch on to the breast.

14. The organisation of health care has meant a lack of continuity of care. Mothers are attended by a succession of strangers, with changing shifts in hospital and different midwives at ante-natal clinics from those who visit the mother at home after discharge from hospital, and so on. There is also a break in medical care for the baby at birth: in utero it is subject to the management of the obstetrician along with its mother; after birth it becomes the province of the paediatrician (Oakley, 1986a). This contrasts with the 'doula' of the natural ideal, an experienced woman who gives complete care through pregnancy, the birth and post-natally, and who knows the new mother as an individual and understands her particular circumstances (Gillie, 1976; Jelliffe & Jelliffe, 1978).

15. Overall, hospitals and medical personnel have been criticised for seeing bottle-feeding as the solution to breastfeeding problems (Van Esterik, 1989). The medical model sees breastfeeding as difficult, with problems being taken as signs that it is not working and should be replaced with artificial feeding (Fisher, 1985). With the natural ideal the emphasis shifts to seeing breastfeeding as a natural process well within the capability of virtually every woman. In the event of problems efforts should be made



to understand and overcome the problem so that the mother can continue with trouble-free breastfeeding.

Overall, the medical model keeps the feeding process (and hence mother and baby) under medical control through medically defined rules and measurements. With the natural ideal the feeding process is allowed to work 'naturally', with the baby in control through the mother responding to its 'demands'. Ideas about breastfeeding and its practice are therefore changing as the medical model gives way to the influence of the natural ideal. However, attitudes and ideas reflecting the medical model still exist, and new mothers are therefore exposed to conflicting ideas as they try to make sense of events in their first attempts to breastfeed.

In the next chapter the earlier historical development of breastfeeding ideas and practices will be traced, together with how these relate to women's social position and power.

## **CHAPTER 5: HISTORICAL DEVELOPMENT OF INFANT FEEDING**

Knowledge and practice of breastfeeding in any society must develop in the context of the culture and social organisation of that society. It is therefore worth examining the historical development of infant feeding practices to show how these are related to women's changing position in society, and also to help show how today's knowledge and practice have also been shaped by the culture and social organisation of our society.

### **5.1 VARYING CULTURAL PRACTICES IN INFANT FEEDING IN PRE-INDUSTRIAL SOCIETIES**

The implication of illustrating the natural ideal by references to pre-industrial societies is that this is the natural and normal method of infant feeding until industrialisation, medicalisation and commercial development of artificial feeding disrupt traditional life-styles and undermine traditional knowledge and practice. However, examination of pre-industrial practices shows wide variation. The details of actual practice are not dictated by 'nature', but vary with custom and belief. So, although our current knowledge of the physiology of breastfeeding makes the natural ideal appear to be what biology 'intends', and despite the inspiration which has been drawn from traditional cultural practices, the natural ideal must still be treated as the cultural product of our own time and society. In acknowledging the importance of breastfeeding for the survival of the human race over the millennia before the development of modern artificial methods, we cannot assume a pre-industrial 'golden age' of 'natural' breastfeeding, or that the survival of the human race is the result of the natural ideal style of breastfeeding.

Throughout the ages, of course, babies have been breastfed, but there is also evidence throughout history and across cultures of artificial feeding also being practised as far back as neolithic cultures and ancient civilisations (Fildes, 1986). Horns, feeding cups, bottles and spoons have been used, and teats have been made from heifers' udders preserved in alcohol (Helsing & King, 1982, p.4), or sponge inside a cap of parchment sewn together so that liquid could flow through the holes of the stitching when sucked (Fildes, 1986, p.344).

It is not always possible to determine what part artificial feeding actually played in a particular culture. Were babies successfully fed completely artificially, or was it used only as a last resort? Such utensils could also have been used to give supplements to otherwise breastfed babies or to aid the weaning process.

Written accounts show that in most of pre-industrial Europe breastfeeding was thought of as the normal and superior method of infant feeding (Fildes, 1986), but there are examples of whole communities where artificial feeding was the norm from birth.

So communities were able to survive without breastfeeding before the development of modern artificial foods and feeding methods, and there is evidence that mortality rates in such communities were not necessarily higher than those of breastfeeding areas (Fildes, 1986). So is this evidence against the superiority of breastfeeding claimed by the promulgators of the natural ideal? I would say not, because in making comparisons in pre-industrial Europe between breastfeeding and non-breastfeeding regions, artificial feeding is not being compared with the sort of breastfeeding practices advocated by the natural ideal. Two obvious variations from the natural ideal were the giving of supplements and non-maternal breastfeeding.

### Supplements to Breastfeeding

From ancient times and across cultures there have been beliefs about the necessity for various supplements to be given to breastfed babies (Fildes, 1986).

A common practice has been delaying the first breastfeeding for several days after birth and giving the baby other substances instead. This could be in the belief either that the first milk (colostrum) was bad for the baby or that the new-born baby had to be purged. Purges were given mainly to remove the meconium from the baby's stomach and intestines, but could also be to prevent diseases such as leprosy and falling sickness, or clearing the mucus from the mouth and lungs by making the baby cough and vomit (Fildes, 1986, p.83). They were normally given at frequent intervals, sometimes for two days (Fildes, 1986, p.82).

The giving of supplements would not necessarily have stopped once breastfeeding had commenced. Other substances might be given for medicinal reasons, or as food if it was thought the breast milk was insufficient. The age of weaning in pre-industrial Europe varied, but the range of custom seems to have been between about six months and three years, although Fildes (1986, Chapter 10) found cases of babies actually being weaned earlier, perhaps because it was thought the baby was not thriving on breast milk, or because breast milk was no longer available.

The foods thought suitable for feeding to babies, whether as supplements, substitutes for breast milk or for weaning, varied (Fildes, 1986, Chapter 8). Animal milks might be used, especially as a substitute for breastfeeding. Then there were 'paps' and 'panadas'. There were various recipes for these, but the three major components of pap were: a liquid (most frequently milk), a cereal, and additives. Some additives were for flavouring (e.g. spice, sugar), and some had significant protein or fat content

(e.g. eggs). The three major components of panada were: a liquid (most frequently broth), breadcrumbs, and additives which again were either flavouring or nourishing (p.214). There were also variations in whether the milks or water were boiled in the preparation of the mixtures (p.217). Another common custom was giving the baby adult foods which had been pre-chewed (p.238), which could transmit disease from adult to baby. Even a baby who was not being given other foods as a regular supplement or for weaning might be fed titbits or snacks from the adult table in a haphazard way.

It was also common to sedate babies to quieten them, for instance with opiates, laudanum, or alcohol (Fildes, 1986, pp.236-8; Fildes, 1988, p.97).

#### Non-maternal Breastfeeding

Another way in which breastfeeding could vary from the natural ideal was wet-nursing or cross-nursing. I use 'cross-nursing' to refer to the sharing of breastfeeding between women to help each other. Palmer (1988) states that in the 17th and 18th centuries in Britain women were 'casual' about suckling each other's children (p.136; also Fildes, 1988).

But of far more significance was wet-nursing where another woman (or women) was paid to breastfeed a baby in place of the mother. In Britain it was customary, since Medieval times, for all upper-class babies to be fed by wet-nurses, and it was a well-paid, respectable job (Palmer, 1988, p.138). For babies of Royalty and the higher aristocracy the wet-nurse came to live in the baby's family home, but it was more usual for babies to be cared for by the nurse in her own home. Wet-nursing in England reached its peak in the 17th and early 18th centuries when it extended to the babies of merchants, lawyers, physicians, clergymen and the gentry, although it was never as wide-spread as in some other parts of Europe (Fildes, 1988, p.79). Parents living in

London might send their children as far as 40 miles away to be wet-nursed, but in more rural areas the wet-nurse was often within a few miles (Fildes, 1986, Chapter 5; Fildes, 1988, p.79). There were also wet-nurses employed by local Parishes and foundling hospitals to care for foundlings. These babies either went to the wet-nurse's home or were fed by wet-nurses living within the hospital or hospice (Fildes, 1986, p.273).

There are various ways in which such wet-nursing was less than ideal in the light of today's knowledge. A baby is born with a certain immunity to infection acquired from its mother, and if breastfed by her continues to receive immunity from her. This protects against the infections to which the mother has been exposed, and so is the best match for the bacterial flora to which the baby is exposed after birth if it stays with its mother. However, being transferred to another nurse exposes the infant to a different bacterial flora (especially if the nurse takes the baby into her own home) to which the baby is susceptible until sufficient immunity factors have been transferred from the new nurse. Also, breast milk changes as the infant grows. It would have been unlikely that a wet-nursed baby would have received milk of its own 'age'. It was common for wet-nurses to take on babies in succession without a break in lactation, and so the milk would have been much 'older' than the baby and so not so well suited to its stage of development. Over-seeing the care of one's baby was made more difficult by the custom of the child being cared for in the home of the wet-nurse. There are on record plenty of instances of wet-nurses being blamed for the deaths of their charges, for instance through carelessness (e.g. 'overlaying') or through feeding the babies inappropriate supplements, drugs or medicines, etc. (Fildes, 1986, Chapter 7). Although wet-nurses would have made convenient scape-goats, standards of general care must have varied, and it is possible that babies which were nominally breastfed were really being

artificially fed to conceal a lack of milk or the cessation of lactation. Privately employed wet-nurses were well-paid and were not drawn from the poorest sections of the community, but parish wet-nurses were not so well-paid and were much poorer women, less likely to be well-nourished themselves or to be in good health or to have adequate homes and facilities. Also, there were cases of parish nurses being given the care of several babies at once, in which case it would be most unlikely that all their charges would be breastfed (Fildes, 1986, pp.275-277). According to the theory of bonding, close emotional attachment between mother and infant would be prevented with the baby being nursed by another, and the general care from someone paid for their services could have been less devoted through lack of emotional commitment (Flandrin, 1979) although there is plenty of anecdotal and legendary evidence of strong and lasting emotional bonds being formed between babies and their wet-nurses (e.g. Minchin, 1985, p.205).

Altogether then, depending on actual practice, it is possible that mortality rates in non-breastfeeding areas could compare well with breastfeeding areas without contradicting our modern knowledge of nutritional requirements and the transmission of infection. When nominally breastfed babies are being subjected to so many variations in practice, a number of factors could have converged to make some child-rearing styles based on artificial feeding safer than some based on breastfeeding. The non-breastfeeding areas were in places of cool climate (northern Europe or mountainous regions) where bacteriological contamination of food before the days of refrigeration would not have been so rapid. Local communities could have had access to reasonably clean water and milk supplies, and they may have developed traditional patterns of hygiene which were appropriate to their environments. There could also have been local variation in the amount of nourishing ingredients included in paps and panadas. Babies

born to mothers who are healthy and well-nourished can be expected to be stronger than those born to women over-worked, malnourished and unhealthy, and standards of general care and safety can also vary. (Fildes, 1986, Chapter 11)

On the other hand, there is plenty of evidence from pre-industrial Britain of artificial feeding being dangerous to babies. Fildes (1986) reports that death rates in foundling homes where babies were artificially fed ('dry-nursed') were 'universally high' (p.275). The London Foundling Hospital, which was set up in 1741, experimented for the first year with artificial feeding, but abandoned it in favour of supervised wet-nursing because it was found that mortality rates were higher with dry-nursing. There are many documentary examples during the sixteenth, seventeenth and eighteenth centuries of breastfeeding being acknowledged as safer for babies than artificial feeding (e.g. Jelliffe & Jelliffe, 1978, p.172). Fildes (1986) found that medical and religious writers before 1700 all saw wet-nursing as the only safe alternative to maternal breastfeeding. In the 18th century some writers recommended artificial feeding in certain circumstances, but only in preference to bad wet-nursing (p.300). The dangers of artificial feeding were frequently emphasised by such writers, especially diarrhoeal illnesses and starvation.

So, in general, across most of pre-industrial Europe, breastfeeding was seen as the usual and best way to feed babies. Next I shall examine details of actual practice in terms of whether they can be seen as the product of a male-dominated, class society.

## 5.2 STRUCTURAL-CULTURAL FACTORS IN BREASTFEEDING PRACTICE

The social implications of women's reproductive abilities have been mentioned in Chapter 2 (p.9). Oakley (1980) has argued that for men to maintain social dominance, reproduction must be under male control. But there are different ways of controlling reproduction and maintaining dominance over women. Culture, custom and



meaning vary from society to society, and women's oppression can therefore take many different forms. It was pointed out in Chapter 3 (pp.22-24) that Oakley distinguished two ways of containing the potential challenge that women's reproductive abilities pose to male dominance. When *separation* is the mode of control, knowledge and management of reproduction belong to women, which does give women immediate control of reproduction, but they are kept under male control through the cultural definition of evidence of reproductive processes as polluting, disgusting or dangerous, and therefore to be kept separate from everyday social discourse. On the other hand, when *incorporation* is the mode of control, women's reproductive abilities are no longer culturally degraded, but directly controlled through knowledge and management being taken over by men, as when it becomes the business of male dominated medical science. Breastfeeding is part of the reproductive process, and how it is practised and experienced will be affected by the form of cultural containment prevalent in a particular society. But with variations in culture, elements of separation and incorporation could be found operating side by side in the same society. Also, how women experience breastfeeding will be set in a whole context of different experiences, which are given different meanings according to their particular cultural milieu.

In Chapter 1 (p.5) the question of whether feminism should be pro-breastfeeding was raised, and I pointed out that if women were prevented through cultural factors from realising a uniquely female achievement, this was a form of oppression of women through loss of control over their own bodies. But I also pointed out that if a woman felt coerced into breastfeeding against her inclination, this was also an experience of losing control over one's own body. Breastfeeding can therefore figure in different ways in the maintenance of women's subservience. In one context women might be denied

the right to breastfeed, and in another breastfeeding might be a means of keeping women from being able to do much else. Also, happy breastfeeding should not be automatically viewed as indicating an absence of oppression, since there are plenty of other ways of controlling women through other aspects of their reproductive role.

### 5.2.1 Pre-industrial Britain

The fact that higher class women were able to pass the task of feeding their babies, along with general care, to women of lower socio-economic status could be construed simply as evidence of class power. In ancient times wet-nurses were often slaves (Fildes, 1988, Chapter 1). In pre-industrial Europe wet-nurses performed these services in exchange for money and goods such as sugar, tea, candles, etc., and with Royal or aristocratic households there could be a certain amount of favour for the wet-nurse's family through her connection with the more powerful family (Palmer, 1988, p.135).

But should this class power be seen as the mother's power or that of the (patriarchal) family of which she was a part? Is breastfeeding necessarily so undesirable a chore that mothers whose families had the means would want to off-load it on to other women? As a physiological process it could be said that there are negative aspects to breastfeeding such as engorgement, and the risk of sore nipples and breast infections which could have serious consequences in the days before antibiotics (Fildes, 1988, p.88). But there is also evidence that breastfeeding could have attractions in certain cultural milieux, such as the close, emotionally satisfying bond between mother and child so often attested to by breastfeeding women (and which seems often to have formed between babies and their wet-nurses), and the fact that lactating suppresses ovulation thus providing a natural method of birth spacing at a time when reliable contraceptive

techniques would not have been available. So breastfeeding need not be viewed as intrinsically burdensome, and reasons for the undesirability of breastfeeding by upper class mothers can be sought in the cultural way of life of higher class families, and the social position of these women within their class. .

That these elite women were subject to male authority and the social mores of their circle is demonstrated by documentary evidence of cases of mothers who wanted to breastfeed being prevented by the husbands/fathers (Fildes, 1986, p.104; Fildes, 1988, p.83), or incurring the disapproval and hostility of other family members and of other women of their social circle (Fildes, 1986, pp.106 & 109; Fildes, 1988, p.84).

Aristocratic families were concerned about producing heirs, and Fildes (1986) argues that the contraceptive effect of breastfeeding must have been known, which would have made breastfeeding by aristocratic women undesirable to these families. In the 17th century it was not uncommon for aristocratic women to have eighteen or so pregnancies, whereas 'country women', who married later and breastfed their own children, and possibly others as well, rarely had more than seven children, and this was not because of excessive mortality. Records show more birth spacing among the poor than the rich (Palmer, 1988, pp.125-6).

The fact that sexual intercourse during lactation was forbidden by the Roman Catholic Church could also account for husbands not wanting their wives to breastfeed, although Fildes (1986, pp.104-5) argues that this was not widely observed in pre-industrial Britain. However, it created a problem for the Church which also forbade extra-marital relations, and so for several hundred years before the 18th century Roman Catholic theologians recommended wet-nursing as the solution to the husband's 'frailty' (Palmer, 1988, p.127), thus demonstrating whose interests were being given priority

since consideration of the sexual desires of the aristocratic husband/father (and the safeguarding of his immortal soul) took precedence over consideration of the respective needs and desires of the mother, the baby, the wet-nurse and the wet-nurse's husband.

Strict Protestant sects saw breastfeeding as a mother's God-given duty, and in the late 16th and 17th centuries mothers of these families were more likely to breastfeed than mothers of similar social standing but of other religious views. Fildes (1986) suggests this could be a possible explanation for the much greater use of wet-nurses in France and some other parts of Europe, which were Catholic, compared with England (p.105). But this is not necessarily evidence that women were less oppressed in such sects, since there could be other means of maintaining their subordination to men. For instance, if the sight of breastfeeding continued to be defined as socially unacceptable, it could be a means of keeping women out of public social life.

Upper class women were sometimes accused by writers who advocated maternal breastfeeding in the pre-industrial period of being more concerned with their social pleasures than with their children (Fildes, 1986, p.99). This blames the mothers, but does not examine a way of life which made child-care and breastfeeding incompatible with the normal social round. For the rural woman these things were integrated into everyday work routines and activities, and for her ideas of modesty did not apply to breastfeeding. But for the upper class woman breastfeeding was not socially acceptable, and was an activity associated with lower social status. Not only was breastfeeding incompatible with the upper class woman's everyday activities, but it would also have been hindered by the fashions in clothing she was expected to wear. Breastfeeding also conflicted with cultural ideas of feminine attractiveness since there were fears that it would spoil a woman's beauty and figure (Fildes, 1986, p.101).

There were also beliefs that upper class women were physically too weak and delicate to breastfeed; or that they lacked the desirable personal characteristics which it was believed were transmitted through the milk to the child. Wet-nurses were therefore sought who were not only in good health and had a good supply of milk, but who were also 'placid' (Palmer, 1988, p.34) and 'amiable, cheerful, lively and good-humoured, with strong nerves; not fretful, peevish, quarrelsome, sad or timorous, and free from passions and worries' (Fildes, 1986, p.169). So in cultural belief the upper class woman was disabled in this aspect of female reproductive power, but Fildes (1986) points out that there were ways in which upper class women could literally have been weakened and incapacitated by their life-style.

For instance, it was a cultural requirement throughout the 16th, 17th and 18th centuries, that they wear very tight corsets and restricting clothing from as early as two-and-a-half to three years of age (p.102). Apart from general debilitating effects, the breasts would have been flattened. There could easily have been damage to breast tissue and the nipples which would interfere with the manufacture and delivery of milk.

Altogether then, within the upper classes women were reduced to status objects by their culture, and the uniquely female ability to breastfeed was culturally downgraded. They were breeders of heirs for their male-headed families, but the full realisation of their physical and reproductive abilities was prevented both ideologically and physically.

Lower-class men, however, could not afford the luxury of debilitating the women of their class. Women's labour was needed and valued in a system where the household was the economic unit of production, and physical strength was considered a virtue in a woman. There could be no great divide between domestic work and childcare, and

the work of economic production. Childcare and breastfeeding would have been accommodated as a necessary part of work routines of the female members of the household. (When a woman became a wet-nurse, the custom for her to take the child into her own home was so that her other work commitments would not be disrupted.) These women would not have been hampered by ideas of modesty or social unacceptability. (Wet-nursing was a respectable and well-paid job, often done by tradesmen's wives for instance, which could considerably benefit a household through income and patronage.) Working women acquired the knowledge and skills of childcare and breastfeeding first-hand as they grew up in their households along with the rest of the knowledge and skills they needed as women. In this situation, breastfeeding was a normal, taken for granted fact of life and not seen as problematic.

This is not meant to paint an idyllic picture of the lives of non-upper-class women in pre-industrial Britain. As was said in Chapter 3 (p.33), women were defined by the Church as morally inferior to men and therefore to be controlled by men. Women were therefore subject ideologically and by law to the authority of their husbands (or fathers) who had, for instance, the power to chastise them.

But it seems that women ceased breastfeeding in England as the dominant culture - that which was seen as more civilised and superior - spread down the social scale. The fashion for wet-nurses spread to middle-class families, although it never became as widespread as in France for instance where in some regions breastfeeding came to be seen as undesirable even for working women and their babies were sent away to be fed by women even further down the social scale.

### 5.2.2 Artificial Feeding to Replace Wet-nursing

However, elite families and their medical advisers were not totally satisfied with

wet-nursing. It was not always possible to guarantee a wet-nurse's own good health, the quality of her milk or the standard of her general care. Although some medical and other (e.g. religious) writers advocated maternal breastfeeding as the solution, a number of leading physicians took an interest in developing artificial substitutes as an alternative, and Fildes (1986, pp.288-292) notes that in the late 17th century some English families began experimenting with artificial feeding in preference to wet-nursing (the decisions being made by the babies' fathers in consultation with their (male) physicians). This was at a time when interest was turning to scientific experimentation generally. Complete artificial feeding was controversial, but fathers had the authority to over-rule opposition from the baby's mother or other members of the family. Fildes (1986) cites documentary evidence of how lethal such experiments could be (pp.288-9), but the practice of artificial feeding spread, and by the late 18th century was established as preferable to wet-nursing. There was a proliferation in the new design and production of feeding utensils (e.g. cans and 'bubby pots', and boat-shaped and upright bottles), and more medical interest in the development of substitute foods (p.291).

But by the mid-18th century some upper-class mothers were beginning to breastfeed themselves in preference to both wet-nursing and artificial feeding (Fildes, 1986, p.291). Ideas on family life seem to have undergone a change with more emphasis on a bond of affection between husband and wife (Fildes, 1988, p.119). Historians disagree as to whether children were more loved and cared for, but a change to maternal breastfeeding, with artificial feeding as the alternative, does mean that babies were no longer being sent away to someone else's home for the first few years of their lives. The greater emphasis on a bond of affection between husband and wife might be taken as a sign of greater sexual equality. On the other hand, if women were being

identified more with the caring work of raising children, including breastfeeding, this could be a means of keeping them occupied with domestic concerns and excluded from the public world. But the fact that artificial feeding was being developed as an alternative to breastfeeding suggests that breastfeeding was still culturally unattractive - not a 'nice' occupation for a lady and incompatible with social life.

### 5.2.3 Changes during the Industrial Revolution

Industrialisation gained pace in the late 18th century, with rapid urbanisation, and household production being replaced by individual wage labour in factories.

#### The Working Class

For working-class women economic participation became incompatible with baby care and breastfeeding. Employers did not want children below employable age brought by their mothers into the factories, and made no provision for creches or nursing breaks. Labour was easily replaceable, and employers were not concerned with looking after the health and welfare of their employees or their families, which were seen as domestic concerns to be met in the workers' own homes. So, babies had to be left in someone else's care while the mother went out to work. Artificial feeding (and drugging infants to quieten them) increased, and infant mortality rates soared.

During the 19th century factory legislation restricting the employment of women and children was passed on the assumption that women should care for children in their homes supported by the husband/father. But in practice women could not depend on male support - wages were low, employment unpredictable, and husbands could be lost or unreliable. Working-class women continued to seek employment, but were disadvantaged in their market situation by restrictive legislation and by the growing Victorian ideology of a woman's place being in the home.



But working-class homes were not conducive to caring for the health and welfare of their occupants anyway. Slum areas were grossly overcrowded with inadequate housing, bad sanitation and inadequate, contaminated water supplies. There were also problems with adulteration and contamination of food.

### The Middle Class

For some 'trades' people there were new fortunes to be made, and a new, rich middle-class rose to prominence and economic dominance. One of the signs of a successful man of business was that his wife did not have to contribute her labour to the family business, or seek employment elsewhere. The Victorian lady was kept in ornamental idleness and economic dependence at home, bearing children and overseeing the running of the home by household servants.

With the process of industrialisation wet-nursing lost its respectable image. The changes in women's employment patterns meant that there were no longer respectable wives of tradesmen or of similar social standing who, having reared their own children, combined wet-nursing with their other work in their own homes. Also, families no longer wanted to send their babies away, and so wet-nurses were required to live in the baby's family home. Therefore, the sort of woman now offering her services was likely to be a young, inexperienced woman who had become pregnant out of wedlock, who had little or no other means of support, and who could undertake wet-nursing as an alternative to prostitution. As wet-nurses were not allowed to bring their own babies with them to their employers' homes, wet-nursing was now associated with the neglect or abandonment of the nurse's own baby. In Britain wet-nursing lost both popularity with the wealthy classes, and medical approval, and was relatively rare in Britain by the twentieth century. But in other parts of the world, both industrialised and non-

industrialised, it continued until the 1940s at least (Fildes, 1988, p.242).

So, increasingly for the mothers of the wealthy classes in Britain, the choice was between feeding their babies themselves or artificial feeding, and, as a social norm, wet-nurses were replaced by nannies.

With the rise of the 'scientific expert' the 19th century saw the proliferation of advice literature for middle-class mothers on domestic matters and child-rearing, and there were also further developments to aid artificial feeding. For instance, rubber teats and glass bottles offered a potentially more hygienic way of delivering feed to the infant. In 1853 condensed milk in cans was developed in America, and evaporated milk in 1885 (Minchin 1985, p.210). In the 1860s an artificial baby food was developed made of wheat flour, cow's milk, malt flour, bicarbonate of potash and pea flour, which was marketed as the 'perfect infant food' and was said to be suitable for newborn babies because it had the same ingredients as mother's milk (Palmer, 1988). It was commercially successful, and other products soon followed. By today's standards they were all nutritionally inadequate, and posed risks from bacteriological contamination. Nevertheless, they were marketed as perfect substitutes for mother's milk (Minchin, 1985, p.210).

There were also 19th century inventions (or developments of already known devices) to 'aid' breastfeeding: breast shields (made of wood, lead, glass or glass and rubber), and devices for expressing milk and/or delivering it to the infant without direct suckling from the breast. Advertisements for these products invoked medical approval, and presented breastfeeding as a painful and messy process which therefore necessitated such products. Minchin (1985) condemns these products outright. The use of lead could expose infants to lead poisoning; the lack of adequate instructions for cleaning,

and the often difficult-to-clean structure, could lead to contamination; and she believes they were physiologically unsound and would have made breastfeeding more difficult or impossible. 'As a means of promoting weaning, they must have been superb.' (p.145)

#### 5.2.4 19th/20th Century Medical Attitudes and Influences

By the end of the 19th century there was considerable interest in the subject of infant health and feeding on the part of doctors and public officials. However, the net effect was to encourage artificial feeding through a process which saw the advancement of the professional interests of doctors (in particular paediatrics as a specialism), and the commercial interests of the producers of baby foods.

#### The Upper and Middle Classes

During the 19th century doctors had found a lucrative market tending the delicate ladies of wealthy families (see chapter 3). There had also been a proliferation of expert advice literature aimed at the middle-class woman on childcare and domestic matters. Some of this advocated breastfeeding, often condemning mothers who did not for their selfishness (Lewis, 1980, p.69). Again, this blames the mothers without taking account of social circumstances such as the fact that breastfeeding was completely unacceptable in polite social gatherings, fashionable clothing was not designed to allow it, etc.

Also, the regimes recommended by doctors for breastfeeding mothers would have made it an unattractive prospect, e.g. restricting one's social life, avoiding sexual emotion, eating a boring diet and resting (Minchin, 1985, p.208). On the other hand, there was little interest by doctors or other experts in the actual process of breastfeeding, or advice on how to do it and how to deal with problems. What advice there was would often, in the light of today's knowledge, have been unhelpful, e.g. preparing the nipples with alcohol, scheduled feeding, the recommendation of supplements while establishing

breastfeeding, and the devices referred to above.

There were also doctors and childcare experts who advised that breastfeeding was old-fashioned, that it was demeaning and cow-like, that women no longer had the stamina, or that women's bodies were too susceptible to emotional disturbance to be trusted to produce milk adequately (Minchin, 1985, pp.208-9).

Against the lack of medical interest in the process of breastfeeding, was considerable medical interest in developing and improving artificial feeding. The medical response to the successful commercialisation of patent infant foods was to argue that artificial feeding should be under medical supervision (Minchin, 1985, p.211). Doctors began developing their own modified cow's milk foods based on complicated mathematical calculations which had the attraction of apparent scientific precision. The wealthy mother consulted her doctor for a formula devised individually to suit her baby, returning every few weeks to have the baby's progress checked and the formula adjusted (Palmer, 1988, p.175). The formulae were made up at special milk laboratories (Minchin, 1985, p.211).

However, this system could not compete with widely advertised patent foods which were cheaper, and which any doctor could simply recommend. So there were mutual benefits to be gained from an alliance between the medical profession and the baby milk manufacturers. By co-operating with the medical profession in the development and marketing of their products, the manufacturers gained the prestige of medical approval. At the same time the manufacturers could advance professional medical interests by helping to make infant feeding a medical matter. Their advertisements to the lay public directed mothers to consult their doctors for recommendation of the product and instructions for use. *The products themselves were*

marketed without any instructions for use, although nothing was done to restrict sales to only those mothers who could afford to pay for medical consultation in addition to the cost of the product (Palmer, 1988, P.176).

The infant food industry expanded in the early 20th century despite medical evidence of higher mortality rates in bottle-fed babies (Palmer, 1988, pp.180-1). The doubts raised by some paediatricians who advocated breastfeeding did not prevail. The medical profession acknowledged breastfeeding as the best feeding method, but continued to approve of co-operation with the manufacturers and the medical supervision of artificial feeding (Palmer, 1988, p.178). Behind the medical profession's official approval of breastfeeding, their lack of interest in it as a physiological process meant that when mothers encountered breastfeeding problems, that was defined as their failure, and it was then their responsibility to seek medical supervision to ensure the success of artificial feeding.

The baby food manufacturers' co-operation with the medical profession ever since has included: gifts and hospitality to doctors; sponsorship of conferences and research grants; free samples to doctors, hospitals and clinics; advertisements and health education posters bearing manufacturers' logos for use in clinics etc.; literature for distribution at clinics and hospitals; and numerous sundry items such as memo pads, cot labels, calendars, etc. bearing manufacturers' logos (War on Want, 1982; Palmer, 1988).

### The Working Class

By the end of the 19th century there was official public concern about the health of Britain's working-class children. Infant mortality rates were used to gauge the state of children's health. Neonatal mortality was assumed to be mainly due to inherited factors, and so interest was focused on reducing infant deaths between one month and

one year. These were mainly due to infectious diseases, and in particular diarrhoea. It was known that outbreaks of diarrhoea were associated with urban areas, hot summers, poor sanitation and bacterial contamination of milk, but the aetiology of the disease was not understood and there was disagreement about its source. When it came to taking action it was easier to blame the mother. It was assumed to be her responsibility to protect her family, and that babies died because working-class mothers were too ignorant or feckless to do this properly (Lewis, 1980, Chapter 2). Therefore at the end of the 19th century it was decided to educate working-class women in hygiene and in childcare. It was observed that breastfed babies had lower mortality rates than bottle-fed even in poor sanitary conditions, and so mothers were encouraged to breastfeed and not to go out to work (although artificial feeding was far more prevalent among middle-class mothers). Lewis (1980, pp.72-3) says that when working-class mothers did not breastfeed it was usually because they tried but failed. She mentions such factors as mothers having to get up before being fully recovered from giving birth, not having enough to eat, and falling sick, as causes of breastfeeding failure.

The education campaign was put into action through the school curriculum for working-class girls, and for mothers through health visitors coming into the mothers' homes, and through mothers' voluntary attendance at clinics. At the turn of the century milk depots were set up in a number of English towns, following a French innovation. Mothers were encouraged to bring their babies to be weighed, and they would be given advice on feeding, childcare and hygiene. Breastfeeding was officially encouraged, but these depots were set up to distribute uncontaminated baby milks at a subsidised price or free. Other clinics were established on similar lines, with classes for mothers as well, although what attracted mothers most was the cheap milk and the chance to discuss

health worries as these women were unlikely to be able to afford to consult a doctor. However, the medical profession opposed the giving of free treatment, and so medical services did not extend beyond diagnosis and advice.

Again the lack of interest in breastfeeding itself meant that little helpful advice could actually be given for mothers encountering problems, whereas mothers did receive instruction and advice on artificial feeding together with cheap or free baby milk products. Armstrong (1983) argues that the surveillance of working-class babies by health workers was achieved through the inducement of subsidised, clean milk. But the supplying of milk did not last. For one thing it was too expensive to maintain, and for another it conflicted with the aim that the clinics should be used for educational purposes (Lewis, 1980, p.108).

### 5.2.5 Twentieth Century Health Care

But, coming into the twentieth century, it was middle-class mothers who led the way with adopting bottle-feeding. It can be said that the cost of artificial foods would be of less significance to them than working-class mothers, and differences in life-style would make breastfeeding less attractive to them. For instance, at a time when not having to combine motherhood with outside employment was coming within the reach of working-class women, the modern image of the liberated woman of the 1920s was one who was involved in the public world with men, not confined to the home with children. Jelliffe & Jelliffe (1978) therefore argue that artificial feeding became a symbol of liberation to young middle-class women along with cigarette smoking, bobbed hair and the contraceptive diaphragm (p.189).

But middle-class women were also more eager to follow modern expert advice based on 'scientific' knowledge, and to use modern medicalised health services.

Hospitalised childbirth was being encouraged by the medical profession as the means to reduce maternal mortality rates, and middle-class mothers were the most enthusiastic users of what were seen as improved maternity services. So middle-class mothers were more exposed in hospital to routines and practices based on the medical model which has since been blamed for contributing to breastfeeding failure. Medical advice and literature also reflected these ideas. By the 1920s medical professionals were the providers of correct rules of procedure which reflected the aim of control: germs could be controlled by observing strict rules of hygiene; child-care advice emphasised routine and discipline; and infant feeding was a matter of measurability and calculation.

Although it is difficult to know how far mothers' practice in the home followed medical advice, there is evidence of middle-class women at least trying conscientiously to put the ideas into practice. The most popular baby manual writer in Britain was Sir Frederick Truby King:

*I was caught up in the Truby King Mothercraft doctrine of 1935...The health visitors prated and bullied; one's baby screamed and tears splashed down one's cheeks while milk gushed through one's jersey. But one must *never* pick the baby *up* - it was practically incestuous to *enjoy* one's baby, so I gathered, young, obedient, motherless, indoctrinated mother that I was...In my day we were instructed that frost never hurt a baby yet, and if the baby cried it must be *mastered*. Working-class women cuddled their babies up in the warm as women had done for millions of years. We, the young graduate law-abiding wives of the thirties,*



cried *ourselves* as our babies went blue with cold...

(Newson & Newson, 1974, p.62)

During World War II the government gave further support to the manufacture of artificial baby food by selling its own product, National Dried Milk, at subsidised cost at clinics. This continued until 1975 when it was withdrawn because of evidence of babies having been harmed by the formula. By the 1960s bottle-feeding was the norm, with hospitals routinely administering lactation suppressants to women on post-natal wards. The baby milk manufacturers maintained their close links with the Health Service and medical professionals, and they became seen by the public as experts in infant feeding. Their leaflets and packaging were referred to for instructions on how much to feed a baby, how often, at what ages to increase the amounts, and when and how to begin weaning (Jelliffe & Jelliffe, 1978). Weaning foods were also developed: cereals to mix with milk, meals either purréd in jars or tins or powdered to be mixed with milk or water, and various types of rusks which could be used either as finger foods or mixed with milk.

Paediatricians acquiesced in a trend to earlier weaning (Jelliffe & Jelliffe, 1978, p.201). In the 1920s 'it was still customary for pediatricians to recommend semi-solids only at the end of the first year' (Vahlquist, 1975, quoted in Jelliffe & Jelliffe, 1978, p.201). Paediatric text books reviewed by Jelliffe & Jelliffe (1978, pp.201-2) show recommended ages for beginning weaning as four to six months in the 1940s, three to four months in 1959 and the early 1960s, and two to four months in 1972, with the attitude that babies can thrive on milk alone until the recommended ages but introducing solids earlier would do no harm. In 1978 Jelliffe & Jelliffe said that in practice many mothers were starting as early as a few weeks (p.200). Since then medical opinion has

shifted against very early introduction of solids. In Britain the Government recommendation is now three to six months (DHSS, 1988, p.53).

But even for breastfed babies the period of breastfeeding has become shorter. Since World War II it has become customary for breastfeeding to last only three to six months, and then be replaced by cow's milk or formula (Palmer, 1988, p.195).

Considerable changes which reflect the influence of the natural ideal have been made in medical practice and attitudes, although the profession has been reluctant to acknowledge the contribution of lay organisations or to be seen responding to public opinion. Rather, changes have been made only when they can be justified in terms of the findings of 'scientific research' (Oakley, 1986c). But, as scientific knowledge is socially produced and reflects the concerns and outlook of those doing and accepting the research, the influence of growing consumer pressure and public opinion cannot be dismissed.

### 5.3 HEALTH PROBLEMS RESULTING FROM ARTIFICIAL FEEDING

Despite the availability of proprietary brands of formula milks, before the 1960s most artificially fed babies were given formulas made up at home based on evaporated, condensed or whole milk. The proprietary brands were 'nothing like the complicated mixtures they are now' (Palmer, 1988, p.271), even though in many cases the names remain the same. By today's standards none of these forms of artificial food would be considered suitable for babies. The resulting high rates of morbidity and mortality from infections, malnutrition, brain damage, anaemia, etc. were less obvious than they would be now 'because the death rate declined over this period due to improved living standards, sanitation, antibiotics and so on.' (Palmer, 1988, p.271) Many of the changes in manufacturers' formulations have been to correct defects which have become apparent

through harmful effects observed in babies. (Other reasons for changes in formula milks have included: trying to make the product a closer match to human milk or more nutritionally adequate in light of new knowledge; gaining a 'technological promotional advantage over rivals'; and replacing ingredients with cheaper alternatives (Jelliffe & Jelliffe, 1978, p.205).)

Palmer (1988, Appendix 1) has three pages of listed known problems and mishaps associated with artificial feeding throughout the world from the 1960s to 1986, those after 1978 naming the specific products. These are problems of inadequacy or unsuitability of the formula, or of faults or contamination in the production process. Many of these are known to have resulted in the ill-health or death of babies. But there may be other less obvious problems associated with artificial feeding with long-term implications. Already studies have raised questions about the association between artificial feeding and increased likelihood of allergy, heart disease and diabetes later in life (Schwab, 1979; Palmer, 1988; Prentice, 1990; Renfrew et al., 1990; NCT, 1992).

Another way in which artificial feeding has had tragic results for babies, and on a massive scale, is through the promotion of baby milks in countries of the Third World to mothers who lack the resources to use them safely (Chetley, 1979). Having developed the market in advanced countries, in the 1960s manufacturers began to put concentrated effort into developing new markets in Third World countries. Extensive advertising presented an image of bottle-feeding as the modern way to feed, part of the affluent Western life-style being aspired to in those countries, thus encouraging the view of breastfeeding as less civilised, and done only by the poor and culturally backward. Bottle-feeding was also presented as a reliable, healthy way to feed, with images of plump, happy babies. Mothers' confidence in their own abilities was undermined by the

constant suggestion that fretful babies were not satisfied, that the mothers' milk must therefore be inadequate, and that infant formula was needed. Companies employed 'milk nurses' who were sales representatives dressed in nurse-type uniforms and who visited hospitals and clinics to give 'advice' on feeding and distribute free samples (Bader, 1981). This was at a time when western style medical services and hospitals were being developed in these countries, which would have disrupted women's traditional practice and sources of knowledge and support, and further undermined their confidence to breastfeed as they had in western countries. Manufacturers gained the co-operation of health professionals with the same sorts of gifts, donations, free samples, etc. as mentioned above, but on a lavish scale which would be significant in poor countries with fewer resources to devote to health care. The manufacturers did not attempt to target their products only at those mothers who had the resources to use them safely. Millions of babies have died from diarrhoea and starvation because their mothers were not literate enough to read the instructions on the packet, because they lacked clean water supplies and efficient means to sterilise bottles and teats, and because they were too poor to afford sufficient formula and consequently over-diluted feeds to make it last.

Various doctors in these countries attempted to explain the problem to the baby milk manufacturers, but met with no response (Palmer, 1988, pp.201-2). The problem was publicised world-wide, and eventually, after considerable resistance from the manufacturers, the World Health Organisation (WHO) produced a Code of Marketing of Breastmilk Substitutes which in 1981 was overwhelmingly approved at the World Health Assembly (Palmer, 1988, p.221).

#### Summary of the WHO Code's main provisions

1. No advertising of breastmilk substitutes.

2. No free samples to mothers.
3. No promotion of products through health care facilities.
4. No company mothercraft nurses to advise mothers.
5. No gifts or personal samples to health workers.
6. No words or pictures idealising artificial feeding, including pictures of infants, on the labels of the products.
7. Information to health workers should be scientific and factual.
8. All information on artificial feeding, including the labels, should explain the benefits of breastfeeding and the costs and hazards associated with artificial feeding.
9. Unsuitable products, such as sweetened condensed milk, should not be promoted for babies.
10. All products should be of a high quality and take account of the climatic and storage conditions of the country where they are used. (Palmer, 1988, pp.223-4)

Despite voting in favour of the Code at the World Health Assembly, Britain has not adopted it to apply in Britain. Instead, in August 1983 the DHSS issued a code written by the Infant Formula Sub-committee of the Food Manufacturers Federation (the FMF Code), which is much weaker (NCT, 1986b). This has allowed manufacturers to break the WHO Code in many ways in Britain since 1983 (Erlichman, 1987).

For instance, artificial foods for babies under the age of six months are no longer advertised to general mass audiences, but bottle-feeding paraphernalia is, including bottles, teats and sterilising fluids (own observation of TV, and video shown in hospital ante-natal clinic waiting room). Formula milks are advertised through specialised channels direct to mothers such as information literature distributed free through clinics and hospitals. For examples, those received by mothers in *this study in 1985 and 1986*

included the Health Visitors' Association booklet *New Baby* which carried two full-page adverts for OsterFeed and OsterMilk, and one double-page advert for Cow & Gate Plus and Premium; and the Family Doctor Publication (published by the British Medical Association (BMA)) *You and Your Baby: Stage 2 Birth to Infancy* had a full-page advert for the Milupa baby food Milumil. All these adverts show the product packaging with pictures of healthy, contented babies clearly visible. Manufacturers also produce educational leaflets, for distribution through clinics and hospitals, on how to breastfeed, and how to bottle-feed, bearing the company logo and sometimes an advertisement for a product. Other items bearing company logos supplied to hospitals and clinics include cot labels (NCT, 1985) and poster blanks (I observed one in my local Health Centre in March 1991 which was being used to advertise the health centre's ante-natal classes and which bore the inscription 'Cow & Gate, the Babyfeeding Specialists').

In 1990 it was found that formula manufacturers were getting round a government ban on free samples and subsidised supplies of infant formula to hospitals by failing to collect on invoices to Health Authorities for milk delivered (Jackson, 1990b).

By appearing to support breastfeeding, and health education in general, the formula manufacturers can launder their image and maintain a stance as experts in infant nutrition concerned with infant care rather than profit-making. Therefore mentioning in adverts that breastfeeding is best can be turned to their advantage - the product being advertised is a perfect substitute for when breastfeeding is not chosen or 'fails'. The manufacturers therefore pose as helpful allies to breastfeeding mothers rather than their rivals. Manufacturers have also offered donations to lay breastfeeding promotion groups. The Association of Breastfeeding Mothers has accepted such donations in one

form or another from Nestlé, Cow & Gate, Farley, Milupa and Wyeth. However, it is the policy of the NCT's Breastfeeding Promotion Group and of La Leche League (GB) to refuse such donations (NCT, 1986d).

#### 5.4 SUMMARY AND CONCLUSION

This chapter has shown the social context of the rise of bottle-feeding in our western culture. Despite acknowledgment by various authorities through the centuries that breastfeeding is best for babies, dominant culture has worked against mothers actually being able to do it. Even when various authorities have advocated maternal breastfeeding, mothers have been blamed for not doing it through selfishness and lack of self-sacrifice rather than attention being paid to the cultural and social changes which would accommodate breastfeeding. Pre-industrially breastfeeding culturally defined as inferior and passed to wet-nurses from the lower social classes. As wet-nursing fell from favour, the return to maternal breastfeeding was accompanied by the development of artificial substitutes as an alternative feeding method. The rise of medical science saw more interest in developing artificial substitutes and medical control of their use than in developing understanding of breastfeeding and working to aid women to do it. The commercial development and promotion of milk foods for babies meant the profit motive taking priority over the health needs of babies, and the autonomy and self-confidence of breastfeeding mothers being actively undermined to render them dependent on manufactured products (e.g. see p.88-89). An alliance between the medical profession and the baby milk manufacturers continues to be to their mutual advantage. Today breasts are primarily defined in terms of sexual attractiveness to men, and breastfeeding continues to be a source of social unease.

Today official attempts to promote breastfeeding have centred on educating

parents about its superiority, and giving practical help and advice to mothers, with some restrictions on the promotion of bottle-feeding by baby milk manufacturers. But is this enough? Mothers make decisions about feeding which seem appropriate to them in the circumstances at the time. In this study I am looking at mothers' experiences and decision-making as they undertake to feed their babies to see how far the social/cultural environment favours or discourages breastfeeding today.

Urging mothers of their duty to breastfeed whilst failing to address cultural factors which work against mothers breastfeeding (through undermining their self-confidence on the one hand, and on the other rendering it an unattractive and inconvenient activity) could be a way of containing the potential challenge to male dominance of this particular aspect of women's reproductive capacity, since the result is likely to be that women's experiences of feeding their babies are of guilt and failure rather than of achievement in a uniquely female activity. This would fit into the general pattern of maintaining male control over women as reproducers distinguished by Oakley (1980) who shows how women's self-confidence and sense of achievement in becoming mothers is undermined in our society.

From a pro-breastfeeding point of view, the problem for women today could be seen as residing in the culturally created obstacles which make breastfeeding in accordance with the natural ideal difficult. However, if the natural ideal is viewed as yet another cultural construction of our age, then it too can be viewed as having ideological power and therefore as part of the problem for women since it sets the standard which women are unable to achieve because of the cultural obstructions.



**CHAPTER 6: METHODOLOGY**

The purpose of the research was to study mothers' experiences of feeding their babies in a modern industrialised western society, and to shed light on why breastfeeding is problematic in such a society.

I wanted to go beyond studying breastfeeding difficulties as the individual problems of each mother to be solved by better advice from professionals or more effort on the mother's part. Breastfeeding is a physiological process, but it is also a culturally defined and managed process, and women's experiences do not merely illustrate the biological technicalities of breastfeeding, or the inadequacies of individual women. They are also illustrative of the type of society we live in, and the position of mothers with their babies in that society.

But to begin with I brought to the research the assumption I had absorbed from pro-breastfeeding literature that I was studying how women *fail* to breastfeed, albeit in their 'social situations' (Lofland and Lofland, 1984, pp.104-5). As the study progressed I increasingly felt that it was more appropriate to say that I was witnessing how these mothers *achieved* the feeding of their babies in the socio-cultural milieu in which they were circumstanced. The actions of the mother in feeding her baby have to be based on her interpretations of events and situations. The socio-cultural milieu shapes mothers' experiences in that it is the context of meanings and structural constraints in which mothers make their interpretations and decisions, and which has a bearing on whether mothers experience feeding their babies with a sense of achievement and personal satisfaction.

The focus on women's experiences and decision-making obviously calls for

qualitative research methods, but I felt severely limited in choosing my methods. From my own personal experience and from that of researchers (e.g. Graham & McKee, 1979; Oakley, 1980) I knew that caring for a new-born baby is physically and emotionally taxing, and for first-time mothers especially is likely to be a time of anxiety and confusion. It is also something which takes place in the privacy of the family home to which I had no right of access. There was no way I could research my subject without disturbing the 'naturalism' of the setting. My presence as a researcher must inevitably interrupt the normal flow of domestic events. I would also be dependent on the co-operation of the mothers I was studying to allow me to intrude into the privacy of their lives at such a busy, taxing time. I therefore had to keep my intrusions and demands on the mothers to a minimum. Direct observation over time was therefore out of the question. Besides, I was interested in discovering the women's developing experience rather than just knowing what they did, and for this 'intensive interviewing' was considered necessary (Lofland & Lofland, 1984, p.12), because really I was studying what Kotarba has called, 'amorphous social experiences - those facets of everyday life that are unique to individuals and not (to) specific kinds of settings...(those) existential experiences of self, rich in their social forms...' (Kotarba, 1980, p.57, quoted in Lofland & Lofland, 1984, p.14).

I decided therefore that the only way I could collect data was by visiting the mothers to interview them in their own homes. However, they would be focused interviews, more like 'guided conversations' than interviews, so that the women could express themselves freely and the patterns of their experience could emerge from the data rather than pre-formulated hypotheses being imposed by me.

In feeding their babies the mothers would be going through a period of learning

and adaptation, and their babies' feeding requirements would also be changing as they developed. I therefore decided this would have to be a longitudinal study to follow the mothers' breastfeeding 'careers'. Each mother was therefore to be interviewed three times. The first interview would be before the birth to ascertain expectations, hopes and fears, etc. The second would be about a month after the birth when the new mothers would still be in the early stages of feeding and their memories of beginning feeding in hospital and coming home would still be fresh in their minds. On the other hand, it was hoped that a month would allow sufficient time for the new mothers to feel settled enough to be able to cope with the intrusion of an interview. The third interview would be when the baby was about five months and the mothers would have started the weaning process. My original assumption was that the introduction of 'solid' food would herald the end of the breastfeeding experience for most mothers, and so the third interview would be mainly for the mothers to look back on their experiences. In practice, though, it became apparent that women who were still breastfeeding at five months had a significant part of their breastfeeding careers still before them with new unknowns to meet and decisions to be made, and so I decided to contact these mothers again by telephone at about one year (or sooner if the cessation of breastfeeding had seemed imminent).

## 6.1 THE SAMPLE

### 6.1.1 Sample Size

As this was a qualitative study involving a series of three in-depth interviews conducted by a single researcher who had to travel to the interviewees' homes, for practical reasons I had to restrict myself to a relatively small sample. On the other hand, it was decided to include as many as possible to allow a certain amount of

comparison between mothers with different characteristics, in particular social class. It was therefore decided to aim for a maximum of 50 women.

### 6.1.2 Criteria for Selecting a Sample

#### First-time Mothers

I decided to restrict the study to women having their first babies, for a number of reasons. Today's small, insular nuclear family structure means that women seldom have opportunities for becoming familiar with babies and baby-care, including feeding, before having their own. In becoming mothers for the first time they are entering unknown territory, and this is the time when uncertainty and anxiety are likely to be most acute. This is not to assume that mothers of second and subsequent babies who attempt to breastfeed are unlikely to encounter problems, but their experiences will be different as they have their previous experience to draw on in deciding how to feed the new baby, and in interpreting events. Also, Graham & McKee (1979) found that having to accommodate the demands of one or more older children was an added complication for mothers attempting to breastfeed. So the breastfeeding careers of experienced mothers are interesting but deserve study in their own right. With the smallness of my sample too many variables could hinder the discovery of patterns of experience, and so I decided to restrict this study to mothers having their first babies.

#### Lay Support Groups

As part of the movement to revive breastfeeding, various lay organisations have been formed over the past twenty-five years or so to promote breastfeeding, and to provide support for breastfeeding mothers in the form of information and education, counselling for breastfeeding problems, and support group meetings. I decided to include a sub-sample of mothers who had this sort of support to allow comparisons with

mothers who had only the support of the NHS professionals and their own social networks.

### Social Class

I had to take account of the fact that 'women' are not a homogeneous group in society. Women become mothers in all social classes, and as class affects life situation this must be relevant to women's experiences of motherhood of which feeding their babies is an important part. I therefore decided to include in the sample sufficient numbers of women of different social classes to allow comparisons to be made.

#### 6.1.3 Recruiting the Sample

Interviewing the women in their own homes was going to involve travelling, and so for practical reasons the women were recruited from a single area, in and around a small town in Surrey. This is an affluent suburban area in the heart of the 'stockbroker' belt. Obviously a single area cannot claim to be representative of all western communities, but such an area is very much a product of western society. The study is therefore illustrative of a process as it occurred in one particular area of an advanced industrialised western society.

The number of women taking part in the study was 47. They were recruited through the local branch of the NCT (10), the local maternity hospital (28), and through being introduced to me by mutual acquaintances who knew of my research (9).

The only breastfeeding support group in the area was the NCT, and so this was the organisation I approached for my sample of 'support group' mothers. Two breastfeeding counsellors each allowed me to attend one of their ante-natal classes, at which I introduced myself to the expectant mothers, explained my project and gave out a written summary (see appendix 2). I avoided indicating a particular interest in

breastfeeding by using only the general term 'feeding'. Seven of the women at these classes volunteered, and a further three telephoned me to volunteer after their NCT ante-natal class teacher had spoken on my behalf and given out my literature at a meeting I did not attend. Five of the women recruited through the hospital and through mutual acquaintances were members of other NCT branches, and this brought the total NCT sample up to 15.

The local maternity hospital (a large, centralised, Consultant unit) seemed the ideal place to recruit expectant mothers since it was NHS policy that all local births should take place there. I approached one of the Consultant Obstetricians who was happy for me to recruit from women attending his clinic. On the instructions of the Director of Midwifery Services I applied for approval by the Ethics Committee which was granted without difficulty. However, the Director of Midwifery Services would not give me access to any information at all about patients. All I was allowed to do was visit the ante-natal clinic waiting-room, distribute my written details to the women waiting there, and talk to them individually.

This proved to be a difficult, time-consuming task, and it took eight visits to recruit the 28 women from the hospital who finally took part in the study. My literature alone was not enough to stimulate the women to contact me, or even to approach me in the clinic, which I find hardly surprising as they were all probably feeling nervous about their hospital visit and pre-occupied with their impending examinations. I therefore had to talk to the women individually and ask them to volunteer. This was not a straightforward procedure in the environment of the hospital waiting-room. Women were entering and leaving at different times, and sat where they chose in the clinic waiting area where the seating was divided into two areas but without any barrier from the rest

of the hospital foyer. There was nothing to stop the women wandering into the rest of the foyer area and mingling with other visitors, which they often did because refreshments were available on the opposite side of the foyer together with more seating. It was difficult therefore to keep track of whom I had approached. Also, they would often be called away for their examinations in the middle of our conversations. In addition, I had no way of knowing in advance who were first-time mothers, and so over half the women I spoke to were ineligible. Recruiting middle-class women proved far easier than working-class as there were more of them and, on the whole, they were more willing to volunteer, and so during my last two visits I concentrated on recruiting only working-class women, but still had to approach all the women initially before I could eliminate the middle-class.

It was extremely helpful to me, therefore, to be able to short-cut this procedure by having women recruited for me by mutual acquaintances who knew of my research.

When women indicated a willingness to take part, I took their names and telephone numbers (or addresses if not on the phone) so that I could contact them again near the expected date of delivery to arrange the first interview. I lost up to a third of my volunteers at the point of trying to arrange the first interview for various reasons such as: they were moving out of the area before the series of three interviews would be completed; health problems, complications with the pregnancy or domestic difficulties had developed; or they felt too busy or over-burdened generally to go through with the interviews. However, no women were lost to the study once their interviews had begun.

I could not assume that all the eligible women approached volunteered. NCT mothers had been addressed as a group of which not more than half had volunteered, and in the hospital talking to the women had often been rushed and confused. In these

situations it was not always possible to distinguish refusals from those who had merely judged themselves not eligible. But there certainly were some refusals, giving the same sorts of reasons as those given by the volunteers who withdrew before the first interview, or giving no reasons at all. It is possible therefore that the sample under-represents women with health problems, complicated pregnancies and births, or in unstable personal circumstances, although there certainly were women in the study who had these problems, and eight women in the study moved house within the district during the course of the study. It is also possible that the sample under-represents women lacking in self-confidence or who were unhappy about becoming mothers. One or two of the women who did volunteer expressed doubts as to whether they would be of any use to the study because of their lack of knowledge of babies or because they did not want to breastfeed (despite my careful neutrality on this point). These mothers were reassured that their experiences would be valuable, but it is possible that others did not volunteer because of similar perceptions, or for fear of being judged poor mothers through seeming incompetent or because they chose to bottle-feed.

#### 6.1.4 Characteristics of the Sample

In recruiting my sample, apart from specifying first births, and being mindful of the need to have a balanced social class composition and to include some women with access to a lay support group, I took what came. As it turned out, the women were all expecting single births (and all were delivered safely). All were delivered at the same Consultant Unit except for two - one was just over the border of another catchment area, and one had chosen the hospital where she had previously worked. Although all the women gave birth to their first babies, taking on the social role of mother need not be related to the physical act of giving birth, and one of the women had previously



mothered an adopted baby from the age of three weeks (now aged nine years). She was included in the study since this was (in her perception) the first time she had the option of breastfeeding.

In deciding how to place the women in terms of social class, I had to consider which aspects of 'class' might be most relevant in this study.

There is a 'conventional' view that the unit of classification is the family using the occupation of the main breadwinner (nearly always male) whose social class will have 'dominance' (Goldthorpe, 1983 & 1984; Erikson & Goldthorpe, 1988). According to this view, the women in my study would be classified by the occupation of their husbands. On the face of it this view seems to apply well to the women in the study since most of them had given up their own employment to be full-time mothers and were dependent on their husbands' wages as family wages. The husband's employment was therefore a major factor in determining the material resources and financial security of the mothers.

On the other hand the women had only recently had jobs of their own. Some were on maternity leave and would be returning. Several others wanted to return to work as soon as they could, at least part-time. Using the 'conventional' approach would discount the importance of the mother's own work experience. The work of Leiulfsrud & Woodward (1987 & 1988) has shown that work experience does affect the life situation of married women, for instance in '(a)ttitudes and orientations toward work, gender roles as related to the division of labour in the home and values in child-rearing.' (1987, p.394) These differences would not apply only so long as the women were employed, since part of the effects of work experience is 'cultural capital' (e.g. 'class related competence in analysis and negotiation' (p.404)), which a woman would not lose

as soon as she gave up her own employment. Feeding and the care of babies are primarily assigned to mothers, and breastfeeding can only be done by them, and so if the impact of work experience on attitudes and levels of self-confidence had any relevance, it would be the mothers' work which would be the most immediately relevant. Also, the financial contribution they had hitherto been making to the household could have a bearing through investment on their continuing material resources (e.g. housing situation and household equipment).

However, classifying women by their own occupation alone does not take into account that women seldom live as individuals but are part of a household and family network. Also, classifying by women's own occupation can result in more of a reflection of the nature of occupational gender differentiation in industrialised countries generally than a reflection of class differences (Oakley, 1980, p.102). For instance, using the Registrar General's scale results in a bunching in Class III non-manual.

In the debate about women's social class, some writers have drawn attention to the significance of women's education (e.g. Abbott, 1987). As education has a bearing on 'cultural capital', this too could be relevant to women's experiences as mothers and of feeding their babies.

I decided therefore to devise a classification system which would combine the elements of the mother's own occupation, the husband's occupation and the mother's education. My composite classification scheme resulted in three social class groupings: Class I Upper Middle Class; Class II Lower Middle Class; Class III Working Class. Occupations were classified by the Registrar General's scheme which was then condensed to three groupings (see appendix 1, table A1.1). Education was judged by standard of qualifications (see appendix 1, table A1.2).

Each woman was given a score (I, II or III) for each of the three elements. For those women who had left their employment, their most recent occupation was used (except in three cases in the study where this had been of a temporary nature, and so the previous permanent employment was taken into account). The composite score was formed by taking the average of the three scores. Thus three Is would give a classification of I, two IIs and a I would give a classification of II, the combination I, II and III would result in II, etc. (See appendix 1, table A1.3.) There was only one case in the study where the mother was not living with the baby's father. Her social class rating based on her own occupation and education was the same as when the occupation of the baby's father was included.

According to this composite system for assigning social class, 19 of the sample were Class III Working Class; 21 were Class II Lower Middle Class; and 7 were Class I Upper Middle Class (see appendix 4). The sample could be said to be over-representative of middle-class women since they are split into two halves (upper and lower) which together form nearly two-thirds of the total sample, whereas the working class is a single group which does not indicate, for instance, differences in financial security and housing situation. In fact, within this group were, at one extreme, married women whose homes, life-styles and aspirations seemed virtually indistinguishable from some of the lower middle-class mothers, and at the other extreme, mothers who were unmarried or married after conception who were still living with their own mothers or in temporary shared Council accommodation while awaiting more permanent Council housing. However, one reason for the bias in favour of the middle-class was the deliberate inclusion of a sub-sample from the NCT, all of whom were middle-class.

It must also be borne in mind that the study was carried out in the heart of the

'stock-broker' belt of the South East, an affluent middle-class area. Working-class women were thus fewer than middle-class anyway, and those that were recruited were used to living in this type of area as against a traditional working-class community or a deprived inner city area. Differences between the perceptions and attitudes of the working and middle-class women in this study are probably therefore less pronounced than they would have been if more distinctively working-class samples had been selected from the sorts of areas mentioned above.

All the women were white, the only mixed race element being that one of the (British) women was married to a black West Indian and her baby was of mixed race descent. Most of the women were British, with British husbands/partners. Three foreign-born women (one French, one Danish, and one American) were settled in this country and married to British men. Also, one woman and her husband who held British nationality were of Italian origin and were living in a close-knit Italian community which maintained the Italian language and culture, and still had links with Italy. Foreign women who were here temporarily included: one French woman whose French husband was on a three-year work contract in Britain, and one Australian woman whose Australian husband was here as a student.

The vast majority (44) of the mothers were married, and there were no separations during the course of the study. Four (possibly five) of these mothers had conceived out of wedlock. A further three mothers were not married during the course of the study, although two were making definite plans to marry the baby's father and were cohabiting with him. The third unmarried mother said that the baby's father had left her, although it is known that he visited her and the baby at least once during the course of the study.

Although all the mothers were asked whether they were married and how long for, I cannot be totally sure that all the mothers who said they were married were in fact legally married. As indicated above, I had some doubts about one of the mothers who gave vague answers about how long she had been married, which made me suspect that she was concealing having conceived out of wedlock, although it is possible that she was not legally married at all but cohabiting. It is also possible that mothers counted themselves as 'married' from the time they began cohabiting. As I felt unable to ask more searching questions without risking giving offence, I had to be content with the evidence I had, which was that all the mothers who claimed to be married certainly appeared to be in marriage-type relationships. As pointed out above, the sample was drawn from an affluent middle-class area, and so an atmosphere of traditional 'respectability' may have been more strongly maintained here than in other parts of the country. But, from the evidence of things like wedding photos on display and the way the women talked about 'in-laws' etc., I have no doubt that the vast majority of women who claimed to be married were in fact legally so, and my main doubts in a few cases are as to whether they had been legally married for as long as they indicated.

The ages of the mothers (at the time of giving birth) ranged from 17 to 39, the median age being 27 years (fig. 6.1), the mean 26.9. (In 1987 in Great Britain the mean age of mothers at the birth of their first child inside marriage was 26.5 years (Central Statistical Office, 1989, p.47). Age was associated with social class in that the working-class mothers tended to be younger (fig. 6.1), but as this reflected the national pattern (Central Statistical Office, 1989) it was decided not to attempt to control the sample for age.

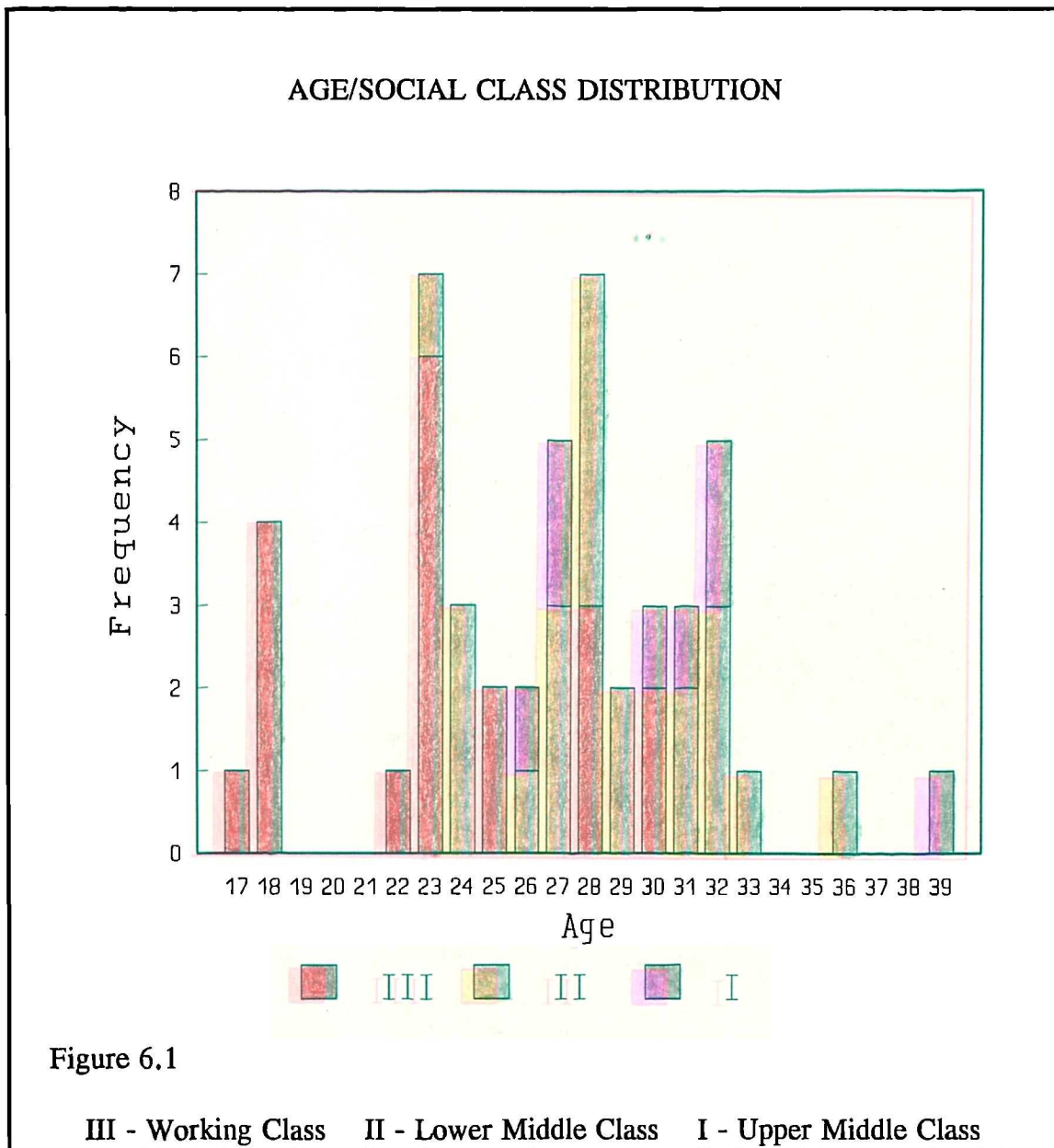


Figure 6.1

## 6.2 THE INTERVIEWS

### 6.2.1 Arranging the Interviews

I arranged each interview with the mother by telephone. In two cases where mothers were not on the phone, one was sufficiently near for me to be able to call at her house instead, and in the other case I did it by post with stamped addressed envelopes for her replies.

The first interview was before the birth to ascertain intentions, hopes, fears, etc. This was timed to take place close to the expected delivery date on the assumption that the women would be well on in their preparations for motherhood, including attending ante-natal classes and studying relevant literature which would be sources of information on breast and bottle-feeding. For mothers who were recruited at less than eight months pregnant, the first interview was arranged at about four weeks before the expected date of delivery which would be close to the delivery date without running the risk of the interview date being overtaken by an early delivery. Those recruited at more than eight months pregnant were interviewed as soon as possible, which in practice meant up to within a day of the birth.

The second interview was timed for about a month after the birth when the new mothers would still be in the early stages of feeding and their memories of beginning feeding in hospital and coming home would still be fresh in their minds. On the other hand, it was hoped that a month would allow sufficient time for the new mothers to feel settled enough to be able to cope with the intrusion of an interview. In practice the timing of the second interview ranged between 3 and 13 weeks postpartum, but most (41) were between four and six weeks. In two cases where the mothers' housing situations seemed particularly unpredictable and their commitment to the research rather weak, I decided to make use of earlier opportunities to carry out the second interview in case they should be lost to the study. Flexibility had to be allowed in fixing the dates for the interviews after the birth because the mothers felt exceptionally busy, and often delays were requested because of things like visits by or to relatives, Christmas, mother's health problems or worries about the baby. But in two cases of very late interviewing, hospitalisation of the baby was a factor, and in a third case the mother's

medical treatment for cancer.

So that I would know when to contact the mothers for this second interview I adapted Oakley's practice in the Transition to Motherhood study (Oakley, 1981b). At the end of the first interview I gave each woman a stamped addressed postcard bearing a simple code which would indicate the sender but which would preserve confidentiality. After the birth the mother simply had to fill in the 'date of delivery' and drop it in the post. In the 10 cases where no postcard was returned, from three weeks after the expected delivery date I telephoned to see if all was well. In every case the failure to send the postcard appeared to be merely a matter of oversight and I was able to arrange second interviews.

The third interview was timed to take place when the baby was about five months and the mothers would have started the weaning process. In practice this meant a range of two-and-three-quarters months to seven months, but most (39) of the mothers were interviewed between four-and-a-half and five-and-a-half months. In the earliest case the interview was brought forward because the mother was about to return to her country of origin. In one case where the third interview was very late, Christmas and the mother's treatment for cancer were factors, and in another case the mother's return to shift work.

Mothers who were still breastfeeding at five months were contacted again by telephone at about a year, or sooner if the cessation of breastfeeding had seemed imminent at the third interview.

To keep track of mothers who moved house during the interview period, I used a system similar to the postcards described above. A postcard for them to record the new address and telephone number was given to them, this time in a stamped addressed



envelope to preserve confidentiality. I gave these to the mothers either at one of the interviews if I was already aware of the possibility of a move, or, if it was mentioned for the first time during the course of an interview, I would send it by post immediately afterwards. In every case the women returned these postcards, except that in two cases moves had been so sudden they were not covered by this system, but I was able to find out the new addresses by enquiring at the old, and so no women were lost to the study.

The interviewing began in December 1984 and the last series of interviews was completed in April 1987. Telephoning mothers at one year to see if they were still breastfeeding was completed in August 1987.

#### 6.2.2 Relationship Between Interviewer and Interviewee

Obviously I was dependent on the co-operation and goodwill of the women I was interviewing. Also, a feminist orientation means that I did not want my relationship with the interviewees to be exploitative, using them merely as a resource for my own purposes (Oakley, 1981b). For both practical and political reasons therefore there had to be some benefit to the mothers as well as myself.

For the women, becoming mothers involved a number of interviews with different health professionals (doctors, midwives, nurses, health visitors) who asked questions of the mothers and who had the authority to make judgements about the mothers' physical condition or her actions in caring for her baby. As an interviewer I wanted to avoid such a hierarchical relationship. I was helped here by the informal, 'guided conversation' style of the interview, and also by the fact that I was a guest in their houses sharing the refreshments which were virtually always provided.

But from the outset, both in asking the women to take part, and in the interviews themselves, I tried to make it clear that my interest was in the mother's point of view.

They were to be the ones making judgements, not me. I justified such an interest by the fact that I was myself a mother who had had to feed babies. I wanted the mothers to see me as a 'data-collecting instrument for those whose lives are being researched' rather than 'a data-collecting instrument for researchers'. (Oakley, 1981b, p.49) I became aware that my status as a student rather than a professional interviewer also helped make the interview relationships more egalitarian, even sometimes to a certain extent putting the mothers in a superior position, as they felt they were helping a student with her studies rather than supplying data to an official.

On the other hand, my status as a researcher and an experienced mother did make me seem knowledgeable. As Oakley (1981b) found in her Transition to Motherhood study, I was often asked questions, and, like her, I endeavoured to answer them truthfully (always making it clear, of course, that I was not qualified to judge the health of the baby). I presented a neutral stance on breast and bottle-feeding, but when mothers asked me how I had fed my babies, I said I had had experience of both. If asked directly which I thought was better, I said I preferred breastfeeding myself, but that I thought it was up to each mother to make her own decision. If asked whether I had been successful at breastfeeding, I answered truthfully that I had had difficulties with my first baby, but was fine with my second and third. I was often asked whether other interviewees were having similar experiences or problems or expressed similar ideas, and I was always able to say truthfully that they were not alone in their experiences. Such questions asked of me were as much a source of sociological interest as the questions I asked them, and the women gained in that I was able, in a limited way, to help meet their need for information or reassurance. I was also asked questions about my research, which again I was able to answer, welcoming the women's interest in the

project. The only way in which I was less than completely open was in not admitting that my main focus was, in fact, breastfeeding rather than feeding in general.

For the women to be willing to have me back in their homes for second and third interviews, they had to gain at least some satisfaction from being interviewed. Possible exceptions were two of the teenagers who remained painfully shy and nervous throughout. Both these women had been asked directly to take part - one by a mutual acquaintance and one in the hospital waiting room - and I suspect that they 'volunteered' through being too passive to say no rather than as a positive decision. With them I felt some guilt that I was imposing the interviews on them and exploiting their feelings of powerlessness.

Otherwise I feel satisfied that the women had made their own decisions to take part, and wanted to help me. Some said openly that they liked the idea of taking part in a study. I also found, like Oakley (1981b) and Finch (1984) that the women liked being able to express their feelings to someone who was prepared to listen and, in a way, share their experiences. There were many comments to this effect, indicating something of a therapeutic benefit. After all, this was a time of momentous events and changes in their lives, with high emotional involvement, but also a time of social isolation in their homes.

But more than this, some explicitly approved of my attempt to represent the mother's point of view, especially at the second interview (a month after the birth) when the women were still in the early days of learning how to care for their babies. Quite often the women seemed to be bursting to talk about the momentous events of the last few weeks, and I was sometimes greeted with expressions like, 'I can understand now why you're interested in this.' They felt there were ways in which their needs were not

met, and they appreciated someone representing their views from an understanding of what it was really like for them.

### 6.2.3 Conducting the Interviews

At the beginning of the first interview I reiterated the focus of the study (i.e. mothers' experiences of feeding their babies from their point of view), asked the mother's permission to use a tape-recorder, and gave assurances about confidentiality. The interviews usually lasted between half-an-hour and an hour, the shortest being about twenty minutes, the longest about two hours. The second interview was usually the longest of the three, when the women had the recent momentous events of the birth and the shock of new experiences to report on. I fully transcribed all the recordings into a written form with the aid of a word processor.

In keeping with the ethnographic approach, the interviewing was 'reflexive' (Hammersley & Atkinson, 1983, p.113). There were no pilot interviews separate from the main sample. From my own previous experience as a mother, and from background reading and preliminary research (e.g. interviews with NCT counsellors) I had already formed some ideas of issues that seemed worth exploring. I therefore had some 'sensitising concepts' (Hammersley & Atkinson, 1983, p.180) as I went into the interviewing. I used a list of questions or topic areas based on these as a guide to the interviews (see appendix 3), but because of the reflexivity of the approach these were constantly being reviewed throughout the interview period, as the details and patterns of the women's experiences emerged.

I did not feel constrained to follow the order of the topics as set down in the guide. Rather I asked non-directive, open-ended questions so that the women could talk freely, and phrased further questions in response to what the women had said, sometimes

to elicit more information on particular issues, sometimes to follow up new leads which had been suggested in the women's accounts. Where appropriate I used more closed type questions, e.g. to test that I had understood what the women were trying to convey.

Non-directive questions were useful as 'triggers' (Hammersley & Atkinson, 1983, p.113) to stimulate the women to talk broadly, especially when opening new topics. Such open-ended questions phrased in general terms also helped to maintain the impression of my neutrality. For instance, I decided the question, 'Are you going to breast or bottle-feed your baby?' was too direct. It would presuppose that the women had made a decision, and it was also the type of phrasing used by health professionals in compiling patients' records, and health professionals are known to favour breastfeeding. I therefore opened the first interview by asking, 'Have you thought much about feeding your baby?' to which the mothers always responded by telling me how they intended to feed their babies and their reasons, or, if they were uncertain, by weighing up the pros and cons and explaining their ambivalence. Only one woman answered with a straight, 'Yes,' but a broader response was elicited by then asking, 'And have you come to any decisions?' In responding to these answers flexibly I was able to continue their discussions and explore with the women their hopes and fears, ascertain the extent of their knowledge, and so on.

I opened the second interview by asking how the birth went, and their recalling of events led on to my being able to ask about first attempts to feed the baby. At the beginning of the third interview I recalled how old the baby had been at the previous interview and summarised how feeding had been going then. This served to elicit confirmation that I had understood what the women had been telling me at the previous interview, and also reminded the women of past experiences and led them to review

what had happened since.

A 'face-sheet' was compiled recording a certain amount of 'factual' information (see appendix 3). Some of the information for this occurred 'naturally' while recruiting and arranging interviews, or came up anyway in the interview conversations, but sometimes I had to ask specifically for the information, usually at the end of the first interview.

The non-standardization of the interviews and the reflexivity of the approach meant that problems and interruptions during the interviewing process could also be used as data. For instance, the reasons the women gave for delaying interviews were related to their situations and experiences as mothers, just as the questions they asked me during the interviews were as sociologically interesting as the answers they gave to my questions since they indicated the mothers' concerns (e.g. 'do all babies have spots at this age?'; 'how many other mothers are still breastfeeding?'). Occasionally there was a third person present for part or all of an interview. It was common for there to be other people in the house (husbands, mothers, relatives or friends) who did not take part other than bringing in refreshments, but sometimes these people sat in on the interview and joined in to a certain extent, either spontaneously or by being brought into the conversation either by the interviewee or myself. I found these contributions a useful addition in studying the context of the women's experiences. For instance, I was able to witness the sharing and comparing of experiences between peer-group mothers, or the passing of information and advice from experienced to new mothers, or hear from husbands themselves how they viewed breastfeeding. On two occasions the interview was interrupted by the unforeseen arrival of the health visitor, which gave me the opportunity to witness such interactions first hand.

### 6.3 SUPPLEMENTARY SOURCES OF DATA

Although I relied mainly on the mothers' accounts of their experiences I also tried to gain an understanding of the context of their experiences through other means. These were useful in suggesting 'sensitizing concepts' before the interviewing began, and also to provide a certain amount of 'triangulation' ('checking inferences drawn from one set of data sources by collecting data from others') (Hammersely & Atkinson, 1983, p.198).

There was, of course, my own experience as a mother which had led me to the subject as a research problem in the first place. I also attended two NCT breastfeeding counsellors ante-natal classes. In addition I interviewed one of these counsellors. There was no local branch of La Leche League and none of the women interviewed belonged to or had contact with this organisation, but I attended a League Leader's support group meeting in another town for comparison, and interviewed the Leader.

I also studied examples of the sort of advice literature which the mothers were using. Some of it was given to me by them, and some I obtained from the sorts of sources available to them (e.g. clinic waiting room, NCT, library, book shops, newsagents, and through responding by post to advertisements by manufacturers and breastfeeding promotion groups which offered free literature.) Whilst visiting the hospital ante-natal clinic I made use of the opportunity to watch the information video which was provided for women to watch as they waited (and which was also used at the hospital's ante-natal classes).

I visited one of the mothers while she was still in hospital to see first-hand the setting of the women's post-natal hospital care, and she briefly showed me round her part of the post-natal ward (a six-bed room, a nursery next door and a sitting-room area just outside) and explained some of the ward routines and practices. I have already

mentioned that I had two opportunities to witness health visitors' visits to the mothers' homes.

#### 6.4 ANALYSING THE DATA

When the interviews were completed and fully transcribed I examined a few selected interview transcripts in depth, coding the women's speeches in terms of the headings and sub-headings that had evolved from the interview guides, although these headings were still subject to modification during this in-depth examination. The headings were not mutually exclusive and so it was usual for speeches to be coded under more than one heading. Comparisons suggested hypotheses, and I then read through the rest of the interviews in light of the headings, making comparisons and looking for evidence to test my hypotheses.

I also drew up summary breastfeeding career charts showing over time how the mothers fed their babies - how long they breastfed for, how often and when bottle supplements were used, and when weaning foods were introduced. In conjunction with this I looked at the details of the development of the experience of a number of women, what their problems were and how they perceived the solutions, and made comparisons. From all this I identified a number of critical points or phases when women were likely to abandon breastfeeding, which led me to divide the feeding careers into stages:

1. Before birth - deciding whether or not to attempt breastfeeding
2. In hospital - attempting to breastfeed (first few days postpartum)
3. Coming home from hospital - carrying on unsupervised and accommodating other commitments (up to three weeks postpartum)
4. Early weaning period - decisions about baby's developing needs (from 9 weeks postpartum)



## 5. Completion of weaning (after six months postpartum)

I then grouped the women in the career charts according to these stages, as shown in Appendix 6 which also indicates the women's ages, social class and feeding intentions before birth. Sheet (i) of the career charts shows the five women who made no attempt to breastfeed (Lorraine, Fay, Brenda, Diana and Trudie) which was in line with their intentions before birth. Sheet (ii) shows that seven mothers who wanted to breastfeed gave up before leaving hospital (Pamela, Priscilla, Nina, Kay, Tracey, Margaret and Stella). Sheet (iii) shows that five more mothers (Mandy, Joy, Barbie, Fenella and Tammy) gave up in the early days at home after leaving hospital. Of these Tammy had indicated before birth that she might breastfeed for only a few weeks. Sheet (iv) shows that nine mothers continued breastfeeding into the early weaning period but gave up breastfeeding between eleven weeks and five and a half months (Roberta, Simone, Sarah, Françoise, Milly, Irene, Connie, Samantha, Fern). Four of these (Roberta, Sarah, Françoise and Connie) had become combination feeders (combining both breast and formula-feeding on a daily basis) before phasing out breastfeeding. Françoise had been undecided before birth how she would feed her baby, and Connie had made a point of indicating she would not continue if she found it onerous. Simone and Milly had indicated they did not expect to continue beyond about two months, Simone because she wanted to start another pregnancy and Milly because she regarded it as normal to stop after a few weeks. Sheets (v), (vi) and (vii) show that 21 mothers continued breastfeeding into the 'completion of weaning' phase (Anneka, Andrea, Michelina, Donna, Vanessa, Hilary, Isobel, Pauline, Nancy, Audrey, Edwina, Gaynor, Sheena, Ruth, Cynthia, Maureen, Valerie, Angela, Gwen, Tabitha and Marcia). Three of these (Donna, Hilary and Nancy) had become combination feeders before introducing

solid foods, and Michelina after. For Michelina and Donna breastfeeding was phased out as bottle-feeding increased, while Hilary and Nancy phased out the bottle-feeding first. Occasionally mothers began giving bottles of formula to help ease the baby off the breast (Edwina and Angela) but this is not counted as combination feeding or a switch to bottle-feeding since the babies were well established on solid foods and the bottle was a temporary measure, the babies having reached a stage of development where they could be healthily fed entirely by cup and spoon. The career charts indicate when milk by bottle was given (formula and expressed breast milk) but do not include drinks of water or fruit juice which all the babies were given at some point even when breastfed. It can be seen that all the babies were fed milk by bottle at some point. Only three mothers (Anneka, Michelina and Gaynor) said their babies were not fed milk by bottle while in hospital, and only three mothers (Valerie, Ruth and Cynthia) said they never bottle-fed after leaving hospital. No baby, therefore, was totally without experience of being bottle-fed before the age of four months, although four (Gaynor, Maureen, Valerie and Angela) said that only expressed breast milk was given (their own or donated).

There was an association between social class and how far mothers continued to breastfeed through the different phases as shown in Appendix 4, middle-class women being more likely to breastfeed and to continue for longer than working-class. There was a slight association between age and whether mothers breastfed or for how long (see Appendix 5), but this was not clear, and as age was associated with social class it is not possible in this study to draw conclusions on age alone.

I have used the same chronology of phases as a framework in the next few chapters for presenting the analysis of the data. As the object is to try and convey the texture of the experience of the new mothers, the analysis is presented descriptively and

illustrated with quotes from the women themselves, rather than statistically. The quotations reproduce the women's own words except where I have edited out excess noises and phrases such as 'um', 'er', 'you know', and 'sort of', and some unfinished phrases. Dashes indicate unfinished sentences in the women's own speech, and dots indicate the existence of speech which I have not included in the quotation. The women's names have all been changed to preserve anonymity.

**CHAPTER 7: BEFORE BIRTH: ENTERING UNKNOWN TERRITORY**

The women in the study were interviewed for the first time shortly before they gave birth. They had all left work, either permanently or on maternity leave, and they were well on in their preparations for motherhood. Although all said they were happy at the prospect of becoming mothers, they also expressed a certain amount of apprehension. Never having given birth before, they wondered how they would cope with this momentous physical event. But they were also aware that this was a time of major change in their lives. Many saw disadvantages resulting from giving up their jobs, such as loss of social status, loss of social contact and friends, loss of outside interest, and loss of income. Another problem was the women's lack of knowledge of babies which meant that although they were looking forward to caring for their babies, they were unable to anticipate clearly what it would be like or how they would manage their day to day care. As a rule their previous way of life had not brought them into close contact with babies, and it was only now that they were themselves approaching motherhood that they had felt the need to learn of such matters.

(Interviewer: Have you had much previous experience with babies?)

No, not at all. I haven't got any in the family. You know, there aren't any in the family, any brothers or sisters. My husband's sister is older and she's got two boys, but the youngest one was six months when I first knew them, so I haven't. More recently friends are starting to have babies and things now, and I sort of play

with them and help them a bit and feel a bit (laughs). I don't like little babies...cos I mean I haven't really had much experience at all with them.

(Isobel:31:1:11)

However, there were five women in the study who had had extensive previous experience with babies. For four of them this had come through their choice of employment. By my social class categorisation, these women represented all social classes. Anneka and Simone (social class II) were qualified nurses who had had experience of nursing babies, especially Simone who had worked in a special care baby unit. Gaynor (social class III) was a qualified nursery nurse who had worked in a maternity hospital, and Fern (social class III) had been employed to care for a baby as an untrained nanny. Sarah (social class I) had gained her experience through having already brought up an adopted baby from three weeks old. *All these women felt their previous experience would help them in caring for their expected babies, although there were still some apprehensions about coping on their own as mothers rather than caring for babies as a job, and about breastfeeding which they had never done before.*

Overall, then, despite looking forward with positive feelings to becoming mothers, the women were also apprehensive and lacking in self-confidence.

### 7.1 THE UNKNOWN ART OF BREASTFEEDING

But the women were particularly lacking in knowledge of breastfeeding. What previous contact they had had with babies was unlikely to include witnessing breastfeeding, partly because of the prevalence of bottle-feeding, but also because of the social embarrassment attached to breastfeeding, which means that it is kept hidden while bottle-feeding is a socially acceptable sight. Many of the women could not recall ever

having seen a baby being breastfed, whereas all of them had at least seen bottle-feeding, and some, particularly working-class women, had even had opportunities to feed other people's babies by bottle themselves. Even when opportunities to witness breastfeeding do arise, social inhibition can prevent observation.

I found it (a film shown at ante-natal class) interesting because you physically saw people feeding up close, whereas even when your friends feed, you can't sort of stare at it like this.

(brackets added)

(Vanessa:12:1:12)

All the women who had extensive previous experience with babies had thereby learned to bottle-feed, and only two, Gaynor (the nursery nurse) and Simone (the Special Care Baby Unit nurse), had also been involved with helping breastfeeding mothers.

Altogether, then, the women were more familiar with bottle-feeding than breastfeeding. However, breastfeeding was by far the more popular choice. Of the 47 interviewed, 41 were definite that they at least wanted to try it.

## 7.2 SOURCES OF KNOWLEDGE AND SUPPORT

All the women made efforts during their pregnancies to prepare for the transition to motherhood. In examining their sources of knowledge and support I shall divide them into 'lay' and 'expert'.

### 7.2.1 Lay Sources of Information and Support

Pre-natally the women looked mainly to expert sources such as ante-natal classes and literature for authoritative information, although they did receive information from lay sources also. They also knew that once discharged from hospital their main sources

of practical help would come from within their own family circle. Such lay information came mainly from experienced mothers, who were of two main types: older generation women (especially the expectant mothers' own mothers and mothers-in-law, but sometimes other older generation *female relatives, family friends or neighbours*); and peer group mothers (relatives or friends of similar age to the expectant mothers whose experience of babies was current or recent). This typology comes from the different ways the women themselves viewed and used these sources of information and help.

But in the first instance most of the women looked to their husbands to be their main source of help and support, and arrangements were being made for them to have time off work to spend a few days at home when mother and baby would first come home from hospital. But these husbands were having to learn parenthood themselves for the first time, and would before long have to return to work anyway. So there was still room for experienced mothers to be useful. It was apparent during the first interview that at least some of the women were already having practical information and ideas passed to them by experienced mothers, and most of the women were planning to have their own mothers or mothers-in-law to help them during the early days after discharge from hospital.

However, these experienced mothers were not always perceived by the expectant mothers as useful. As has been said, they looked to expert sources for authoritative knowledge, and indeed the experienced mothers frequently gave the expectant mothers books on pregnancy and baby-care written by experts - either new ones as gifts or by passing on the ones they had used. But the expectant mothers also frequently saw such experienced mothers as potentially interfering, or almost as rivals to whom they did not want to show their own incompetence. This was particularly characteristic of the

middle-class women, some of whom were actively planning not to have such help in the early days, or at least to keep it within limits, and they seem to have had the approval of health professionals in this.

...he's (husband) having a week's holiday when I come out of hospital, so my mother or mother-in-law *aren't* coming. My mother doesn't live that far away, but also I rather feel that we'll get on better the two of us sorting it out between us. When he's gone back to work I think my mother has every intention, which'll be super, of blowing in with some food for us and doing the odd bit of shopping for us, but I really feel that with his help that'll be the best way for me, knowing that I'm not that good at taking advice from my mother. Even Mrs. Davis the midwife agreed that there is a sort of reaction that people have of proving to their mother or mother-in-law that they can cope, and if you're trying to prove you can cope, and that you're not finding it at all difficult, it almost makes life harder.

(emphasis in original, brackets added)

(Audrey:10:1:17, social class I)

On the whole middle-class women seemed to have more confidence in the baby-care knowledge of peer group mothers which they saw as more reliable and relevant to their own situation. They were aware of changes in expert advice, which made the knowledge of the older generation seem out-of-date. Life-styles and attitudes had also changed, and there had been developments in manufactured baby-care products. Also,



the small nuclear family structure meant that it had been many years since the older generation had been directly involved in baby-care, and it was not expected that they would remember enough details to be useful anyway. So the usefulness of the older generation mothers was seen mainly in terms of helping with housework and giving general loving care.

But some of the working-class women seemed to have closer relationships with experienced mothers, and could talk far more about the problems encountered by sisters or friends with their babies. In fact, working-class women were more likely to have had some personal contact with babies, even sometimes helping other mothers or baby-sitting, although they still lacked previous contact with young babies. There also seemed to be less of a generation gap between the working-class women and their own mothers or mothers-in-law. They were more likely to be in close contact with them, especially their own mothers, and were far more ready to make use of their help and knowledge, being more likely to share their ideas than regard them as out-of-date. Four of the working-class women had such close relationships with their own mothers that it is questionable whether their relationships with their husbands/partners were closer. Brenda and Margaret were both mature women (aged 30) with their own households, but their mothers lived nearby and they saw them everyday or nearly everyday. They were like companions, supporting each other. Mandy and Fern were younger (18 and 23 respectively) and were actually resident, with their partners, in their mothers' homes, having conceived out of wedlock and being still in the process of planning their marriages and separate households. Both these women were still willingly being mothered by their own mothers, especially Mandy. Another working-class mother, Michelina, lived in an extended Italian household headed by her husband's parents, in

which the males did not take much interest in the details of baby-care, and so Michelina discussed such things with her sisters-in-law and mother-in-law rather than her husband.

As far as breastfeeding is concerned, all the women who wanted to do it felt they had the approval of their husbands, which was a matter of importance to them.

I think if my husband hadn't been in favour of it that would have been a big factor. It must be to other women because I think it's got to be both of you have got to be in favour. Well, not dead against it. If my husband was dead against it I probably wouldn't have done it. I couldn't bear the thought of him sort of sitting there being revolted or having to go into a different room or something. It would upset me, so I think it's got to be both really.

(Hilary:1:1:9-10)

Of the women who wanted to bottle-feed, Brenda's husband's opinion did not appear to be a factor in her decision, but Fay, Trudie and Lorraine brought their husbands' attitudes into their explanations for not breastfeeding.

He's not very keen on breastfeeding either...He said that he wouldn't ever get a chance of helping out, and he said you wouldn't be able to leave it with anyone. And it means if you're out and the baby's hungry and crying, I mean you have to sort of-, you know, it's a problem really. I think he gets the impression that it's not very nice for me to actually have to get it out and feed the

baby, you know, in a public place, say if we were out and the baby got hungry, you know, cos obviously you can't be indoors at every feed time. You've got to go out sometimes...

(Fay:21:1:8)

As a rule the women saw their husbands as their closest supporters and co-parents with whom they could share the pleasures and tasks of baby-care. But they were concerned to keep their husbands happy, and did not want their needs as mothers to cause conflict. In this respect working-class women expressed more concern than middle-class. Some women saw the fact that only they could breastfeed as a slight drawback because it could make their husbands feel excluded and jealous. The giving of occasional bottle-feeds or drinks of water by bottle was often mentioned as a possible solution, but the advice some of the women had received from their ante-natal classes that the men could feel involved by bringing their wives a cup of tea while they were feeding was derided as patronising. Some of the working-class women felt that their husband's support for breastfeeding would only last as long as things went smoothly.

I think he's all for it. I mean he sort of says, you know, 'Later on if you want to bottle-feed, well, obviously I can help more,' but I mean he sort of says it's great to give a baby a good start. He's all for this: 'Er, oh yeh, well, you know, it's up to you really.' (laughs) He's very much that way, you know. Well, I think all he's frightened is that I'm going to get like my friend Sally was. You know, get herself in a state about it. 'You know, if you can't do

it, don't worry.' I said, 'Don't be silly, I know.' I think he thinks I'm going to crack up round him (laughs), but he seems to be quite amicable about it all. He said the only thing is he won't be able to get up in the nights with me, but I don't think he's that bothered. (laughs) I don't think he'll be worried too much about it. (laughter) I don't think he'll lose any sleep over me getting up.

(Tracey:26:1:12-13)

The attitudes of other relatives and friends were not so significant to the women, but in general those who wanted to breastfeed felt that such people approved in principle, although some working and lower middle-class women did say they met with hostility in some quarters.

I must admit I've got two sisters, both younger than me, and have both got children, and are both horrified that I'm going to breastfeed...I think they're embarrassed. Socially, that they're embarrassed...

(Priscilla:18:1:1-2)

No one's ever said to me very strongly one way or the other, but I've got some friends who look upon it as a really repulsive thing to do...

(Fern:39:1:4)

But some of the women did pick up a little information from the experience of peer-group mothers who had breastfed. Occasionally this might be of practical use, e.g.

...I'd like my husband to perhaps have one bottle-feed. I

think it would be nice for him to feel that he was doing his bit, and good for the baby to get used to a bottle, not too used to it perhaps, but familiar. So hopefully. My sister apparently did that cos that's what put the idea into my head actually...She said that her husband did one feed. I think it was sort of five o'clock in the morning or something, so she could have a bit of a rest after getting up in the night, and *he* gave the one bottle-feed and that seemed to work for them, so I'm just hoping the same sort of thing might work for us. Give it a try.

(emphasis in original)

(Hilary:1:1:18)

But more often the information was of the dangers and problems which other women had encountered and which had led to the abandonment of breastfeeding.

...my husband's brother's wife had to give up after about four weeks I think because she had a cyst in her breast which she had to actually have an operation to remove, and then she developed one in the other breast as well. Luckily the other one just went of its own accord, but she was told she had to stop breastfeeding, otherwise it wouldn't go. And also, my mother-in-law had that as well when she was feeding my husband...

(Tabitha:4:1:15)

...my sister-in-law, she'd always wanted to breastfeed, and

she couldn't breastfeed either of hers because she just couldn't produce the milk for some reason...the two kids didn't seem to feed and then they found it was just because she wasn't producing enough milk...

(Cynthia:14:1:1)

None of the women who wanted to breastfeed felt any opposition from their own mothers or mothers-in-law, and usually felt they had their positive approval. However, these older mothers were not sources of knowledge on the subject since few of them had experience of successful breastfeeding. Also, the older generation women's ideas were based on the medical model type approach, whereas much of the expert advice which the women were receiving reflected natural ideal type ideas. Most of the middle-class women did not yet feel knowledgeable enough to have strong views on the matter or even to be aware of controversy, and they did not often talk of such matters with the older generation mothers anyway, but occasionally some of the middle-class women were aware of potential conflict over differences in approach.

With my mother it's come up a number of times. I was talking with her a couple of months ago about an article I'd read in the *Nursing Times* about breastfeeding...I mean mum's sort of supportive of breastfeeding but she also does tend to-, I don't think she approves of the idea of demand feeding.

(Maureen:11:1:11)

Such conflict did not seem to affect the working-class women who shared the medical model type assumptions of the older generation more.

In conclusion, with little previous knowledge of their own, and with the knowledge of other mothers not seen as authoritative, the women felt dependent on professional expert sources of information and support in their transition to motherhood.

### 7.2.2 Expert Advice

As has been said, the women regarded the professional expert as the authoritative source of up-to-date information. This included NCT ante-natal class tutors and breastfeeding counsellors who, although not professional or part of the medical establishment, had expert status in the eyes of the women because of their special training and standing in the NCT. In fact, these NCT tutors and counsellors were especially respected and valued because they combined their own personal experience as mothers with 'expert' training, and could look at medical practices with a consumer's eye.

Pre-natally the main sources of expert information were: ante-natal classes; leaflets and booklets issued free to expectant mothers; books and magazines sold through bookshops and newsagents; films, videos and TV programmes.

Ante-natal clinic appointments (check-ups) were not occasions for disseminating information on baby-care or breastfeeding. For most the only mention of breastfeeding at ante-natal clinics was at the first hospital appointment when particulars were being recorded in the patient's file and the women were asked if they intended to breast or bottle-feed. This was in the first half of pregnancy, and often the women said they had been taken aback by the question as they had not yet given the matter much thought. Some women said their nipples had been examined, but this seemed to be done haphazardly. Otherwise matters pertaining to breastfeeding were not mentioned unless the women asked questions themselves. Some women found their GP clinic

appointments afforded more opportunity for discussing general queries, especially with the clinic midwife. But the main way in which the subject came up was if there were breast problems to treat such as inverted nipples or sore and flaking nipples, although some women were given general advice to prepare their nipples by rolling them in their fingers. Breastfeeding was sometimes discussed when the community midwife visited the mother in her home before her confinement. But in general the women saw the ante-natal classes as the main source of personally communicated information during pregnancy.

All in all, then, the women were receiving their education for motherhood in prepared, generalised packages. Books, leaflets, films, etc., are obviously prepared media packages, and the most personal form of communication available to them was the ante-natal class at which talks were delivered to a group of women together with limited opportunities to ask individual questions.

#### Ante-natal Classes

The ante-natal classes attended by the women in the study can be divided into those run by local National Health Service authorities (NHS), and those run by the NCT.

NHS classes were held at such venues as health centres, clinics or at the maternity hospital. The women were offered them as part of their NHS ante-natal care, and they were free. They were tutored by midwives and health visitors. Some were held during the day, and some during the evening.

The NCT classes were held in the evening at the tutors' homes. The tutors were experienced mothers who had also been trained by the NCT. One of the classes would be taken by a breastfeeding counsellor, at her home. The women had to initiate their own contact with the NCT in order to join, and they paid a small sum for the course



which worked out at about £2 per class (in 1985) but which also included a year's membership of the local NCT. In virtually every case the women had first become aware of the NCT through the recommendation or example of friends or relatives, but one woman in the study said her GP had recommended the classes to her when she had expressed a desire for a 'natural childbirth'.

The different ante-natal courses varied in the details of what was taught and style of presentation, but in general they all covered preparation for labour and delivery (including relaxation exercises), and aspects of baby-care (including breast and bottle-feeding). The NHS classes all seem to have included some sort of demonstration of how to make up bottle-feeds. The courses usually consisted of a weekly class for about six weeks, and the women attended them in the latter half of their pregnancies.

All the women in the study attended at least one ante-natal class session except for Diane who did not recall being offered them and assumed this was because she was debilitated by her special medical treatment for cancer. In general the women were quite enthusiastic about the classes and thought them useful. Only three women said they gave up after only one or two (NHS) classes (Lorraine, social class III; Françoise, social class II; and Roberta, social class I), but all three felt they had alternative sources of information particularly through reading.

NCT classes were attended by 15 women in the study, all from social classes I and II. (This proportion of the sample is not claimed to be representative nationally since eleven of these were purposefully recruited as NCT members to make a comparative group with non-NCT members.) Most of these NCT members attended NHS classes as well - only three did not. In general the women thought it useful to have attended both courses. Most felt that the NCT classes were better - more informative

and friendly - although some women reported that they felt certain things had been covered better at their NHS classes.

A major attraction of the NCT classes was that they were an independent alternative to the instruction offered by the medical establishment. The women were aware that criticisms have been made of medical attitudes and hospital practices, and they were interested in the 'natural' approach. They often expressed fears about coming into conflict with medical professionals, especially during the hospital stay.

I've heard that in some hospitals perhaps they have fairly fixed ideas, and if you have any problems immediately they convert very quickly to bottle-feeding, saying, 'Oh well, it's probably for the best,' and then you might find when you get home that it's too late or difficult to actually establish breastfeeding. But I'm going to (name of hospital), as you know, so they seem fairly flexible there...I was a bit worried that they would either try and enforce fixed feeding times, or that during the night they would just bottle-feed. You know, again, you sort of hear different stories from different hospitals...

(Samantha:27:1:4-5, 17)

However, some of the upper middle-class NCT members seemed sceptical of NCT extremism when it came to challenging medical authority. This was a criticism of other NCT class members more than the tutors.

...some people, particularly some people who belong to the NCT I think, are very much geared to making a fuss.

Tanya (an NCT class-mate)...she said last night that she felt she was girding up her loins and going into battle to go and have the baby, and I said, 'Well, I can't think why you say that, they're so nice at (the hospital). All they want is for your best and-' um. I think it's a matter of attitude, some people get brushed up the wrong way. I'm quite prepared to swim with the herd insofar as it suits me. (name of hospital deleted, brackets added)

(Valerie:13:1:19)

(Interviewer: do you think the NCT classes have been useful?)

Oh yes, I do. I think they're sometimes a little bit, not idealistic, but they have some bees in their bonnets that I suspect might irritate the medical profession and I'm rather one for a quiet life, and that if it's something not too important then I would quite happily sort of be a good girl and - do you know what I mean? - get on with it...I have a feeling some of them might be a little bit, 'Oh well, I want mats on the floor,' - a little bit too demanding and forget that the medical profession-, I've got various sort of doctor friends whom I was at University with who say that their main priority's a safe delivery and it's all very well saying it should be a sort of wonderful experience for mother and child and father and all the rest of it, their

priority is to have a safe delivery, which I can understand, and if you get somebody coming in and laying down the law too much, it does irritate them rather, so I'm quite happy to have a-, be a good girl for an easy life in a way. I think some of their things where they say you ought to have it-, you know, squatting is a much more sensible position to give birth, which is all very well if you're a little Indian lady who spends all her time squatting on the side of the river doing your washing, but I couldn't cope with it. My legs would give up. So although it might be ideal, I don't think it's really necessarily always that practical...

(Audrey:10:1:9-10)

Despite the efforts of the ante-natal class teachers (both NHS and NCT) to make their instruction as informative as possible, the women found it difficult to gain a clear idea of the practicalities of baby-care, including breastfeeding, in this way.

It's very difficult. She's sitting there beforehand with people who are, you know, they're going to have a baby in the next couple of months, and (she's) saying, 'Well, you've got to-, the positioning's got to be right, and this has got to be right, and the other,' and you can't imagine it. You can't actually-, you can't practise it. It's not something that you can go away and sort of read up on in a sense, is it? I think you have to wait until you're

actually in the situation...

(Gwen:44:1:4)

Some of the NHS courses included a visit to one of the classes by mothers who had attended the previous course, and who now came with their new babies to discuss their experiences with the pregnant women.

They had some mothers there the last visit, breastfeeding...It was nice actually, cos you could speak to them, and they were telling us their problems and things that were happening. But I think it's one of those things that you can't really be told and shown about. It's practice. I think you've got to get on with it and see what happens. So you can't really give a talk on it really.

(Pauline:34:1:3)

The women also found it difficult to look beyond the actual birth, and some thought the ante-natal classes encouraged a pre-occupation with the birth.

Everything's all geared to before the baby's born, but nobody really tells you much about after the baby's born, or they haven't yet. I presume they go through with that at the hospital, but I think there ought to be post-natal classes as well...OK, they have covered nappy rash and things like that, but there's other little signs of things that you're not aware of until it actually happens...

(Sheena:6:1:33)

NCT members thought that the NCT classes had favoured breastfeeding, and women

who attended NHS classes thought either that the instruction had been biased in favour of breastfeeding or that no bias had been shown in discussing breast and bottle-feeding. No one thought bottle-feeding was being advocated as a first choice. But the women felt strongly that choice of feeding method was a matter of individual choice. This was expressed by women of all social classes including those firmly committed to breastfeeding. A few working-class women felt that the NHS classes had been pushing breastfeeding too strongly, but most women thought that the midwives and health visitors had avoided making the expectant mothers feel under pressure to breastfeed, and approved of the way they had treated bottle-feeding as an acceptable alternative. Those who attended NCT classes did not expect the same lack of bias there since it was assumed that women chose to come to these classes knowing that the NCT favoured breastfeeding.

On the whole the classes were disseminating ideas which reflected the natural ideal approach. This was particularly the case with NCT classes, but there was often evidence of conflicting advice at NHS classes through the influence of ideas from the medical model. For instance, there seemed to be confusion as to what exactly 'demand feeding' meant, although most women were not troubled on this point because they assumed that babies demanded on a fairly regular pattern and it was just a matter of not being over-rigid. Middle-class women who perceived contradictions were not too troubled because they treated them as a repertoire of different ideas which they could choose from to suit their own particular circumstances when the time came.

...I suppose the problem with feeding is the two-. I  
suppose I've just been listening to everybody all the way  
along the line in the hope once it's born I'll try and make

up my own mind, but the midwife will say, don't feed them too often because they then-, if they cry sometimes they can cry cos they've got tummy ache, you put them to your breast and you give them more milk and their tummy ache gets more, and you can get yourself into a real vicious circle whereby your nipples get sore, the baby gets too much milk and in the end it only takes a little bit of milk each time. You're then having to feed it too often. Which is the very opposite really to what the NCT say which is sort of demand feeding, and the more you feed them, you set up the supply and demand situation.

(Audrey:10:1:7)

But some working-class women foresaw practical difficulties with 'demand feeding', and the emphasis on it for breastfeeding sometimes amounted to a disincentive to breastfeed. Here Kay recalls and gives her reaction to a class jointly presented by a midwife and a health visitor:

...there was an older lady there and she was saying one thing, and the young one, she had different ideas against, so she was saying something else...I mean the young one, she said-. They were talking about feeding on demand and things like that. But then some babies are greedy, aren't they, and the feeding on demand, you could be doing it all the time. And the other one (the older one) didn't agree with that (demand feeding)...In theory, she said, it's all

right. With a normal baby who wants it every three hours or something, that's all right, isn't it? But, she said, if you can just do it sort of every three or four hours, then, you know, it's plenty. But otherwise you'd be there all the time. That's what put me off a bit.

(brackets added)

(Kay:38:1:1)

### Films, Videos and TV Programmes

Many of the NHS classes included films on subjects such as the actual birth, general preparations for baby-care, breast and bottle-feeding. These films were often criticised for being dated and unattractive, either as a medium (noisy projection equipment, poor sound, worn out film, etc.) or in style (e.g. old-fashioned clothes). Very occasionally odd details of information were referred to as out-of-date, but on the whole the women did not think that the age of the films discredited the information being presented. Some of the films had been produced by health education agencies (e.g. health authorities) but many had been produced by manufacturers of baby equipment including baby milks (e.g. Farley's). Some women felt this made no difference to the information being presented except that when products were shown in use the brand names were visible, but some were more sceptical about the motives of the film-makers.

At the hospital ante-natal classes a video was used which did carry direct advertising between the different programmes on the tape, including an advertisement for sterilising chemical for feeding bottles. The programmes on the video included one on breastfeeding and another on bottle-feeding. The former recommended breastfeeding, but the latter gave reassurances that mothers need not feel they were giving their babies



second best if they bottle-fed. This video was also frequently played in the waiting room of the hospital ante-natal clinic.

Often the women thought these films and video programmes informative and interesting, but some complained of patronising or corny commentaries, or that details had been presented in an off-putting way.

A few women said they had seen television programmes about babies and baby-care (e.g. 'Baby & Co.'; 'Baby, Baby'), which they found interesting, but none recalled learning anything about feeding from these programmes.

### Leaflets and Booklets

In the course of the ante-natal interviews I was shown a number of leaflets and booklets on matters pertaining to pregnancy, birth and baby-care, which the women had received free at ante-natal clinics and classes. Some of these were produced by health education agencies: the Health Education Council (since replaced by the Health Education Authority), the Health Visitors Association, the BMA, Medical Audiovision Ltd, and B. Edsall & Co. Ltd. Others had been produced by the manufacturers of baby-care products, particularly formula milks. Very occasionally women sent off for offered information packs from manufacturers, and one woman showed me a pack she had obtained to accompany Yorkshire Television's programme 'Baby & Co.' NCT members were also able to obtain leaflets produced by the NCT - some free, some costing a few pence. The women also received an introductory booklet to the hospital where they were booked for their confinements.

Some of these leaflets and booklets covered a number of different topics (pregnancy, birth, baby-care, etc.), and some were devoted to a single topic (e.g. breastfeeding or bottle-feeding).

Out of all these different papers, only the Health Education Council and the NCT ones carried no commercial advertising at all. Advertisements were for all sorts of products associated with having and caring for a baby, including feeding. An inspection of leaflets and booklets shown to me by the women in the study revealed the following advertising for bottle-feeding (contravening the WHO Code).

The BMA's *You and Your Baby: Stage 2 Birth to Infancy* included a full-page advert for Milupa's 'Milumil' (a formula designed for use from birth) and another for Wyeth's 'Progress' (a 'follow-on' formula for use 'from 4 to 6 months onwards'). The Health Visitors Association's *New Baby* carried two separate full-page adverts for Farley's 'Osterfeed' and 'Ostermilk' (headline: 'Q. My baby's always hungry. Is there a baby milk that can keep him contented? A. Yes.'), and one for the Milupa range of products ('from birth through to family foods'). There was also a double-page advert for Cow & Gate 'Premium' and Cow & Gate 'Plus' (headline: 'Nature makes one milk that's perfect for every healthy baby. Why does Cow & Gate make two?'). The Edsall booklet *Breastfeeding* had no adverts for baby milks, but there were two full-page adverts for equipment for expressing breast milk and feeding it by bottle: Cannon 'Babysafe' (headline: 'A breast fed baby doesn't have to be fed by mum') and Robbins Medical Supplies (headline: 'The bottle for breast-fed babies'). In addition an advert for Maws products to do with nappy-changing also mentioned that Maws products include 'bottles and teats'. Medical Audiovision's *Mother and Child* was a magazine-style publication issued to accompany the video shown at the hospital. The only advert in it for formula milk was for the 'follow-on' milk 'Progress', but there was also a full-page advert for Maws teats. The Yorkshire Television information associated with the programme 'Baby & Co.' had no actual advertising, but carried the message 'Project

supported by' followed by three company logos, two of which are associated with bottle-feeding: 'Cow & Gate: The Babyfeeding Specialists', and 'Milton Baby Products' (sterilising equipment for bottles and teats).

The leaflets and booklets from baby milk manufacturers varied in the ratio of advertising to educational material. Cow & Gate's *Cradle Days* covered both how to breast and bottle-feed, and included a page explaining the suitability of the Cow & Gate range of baby milks for babies' varying needs, plus a picture of the tins. There was also a single sheet *How to Prepare a Bottle Feed* produced by Cow & Gate, again including some explanation of the Cow & Gate range with a picture of the tins. Another leaflet from Cow & Gate was a straight forward advertisement for fruit juices 'suitable for baby from four weeks old'. There were two booklets from Wyeth entitled *Breast Feeding Your Baby* with virtually the same text, but different pictures and layout. The smaller one (probably an earlier issue) was entirely devoted to breastfeeding except for an advert on the back cover for 'SMA Gold Cap' (headline: 'If you're unable to breast feed choose Gold Cap SMA: the baby milk that closely resembles breast milk') and 'Gold Cap SMA concentrated liquid' (headline: 'Gold Cap SMA concentrated liquid is ideal for 'top-up' feeds'). The larger (probably later) version carried no adverts but had the logo 'Wyeth Nutrition' on the front cover and 'Wyeth Nutrition: Leading the Way' on the back.

Weaning foods were also copiously advertised, both by leaflets produced by the manufacturers and by advertisements in the other booklets mentioned above.

The women liked receiving these leaflets and booklets, and often appeared to read them closely. Overall they thought them very useful.

### Magazines

Some of the women bought magazines such as *Mother & Baby* and *Parents*.

Articles in these magazines covered topics of interest to new parents such as pregnancy, childbirth, and baby-care up to toddler stage, and often included guidance on breast and bottle-feeding. As far as advertising of bottle-feeding is concerned, there were no adverts for formula for new-born babies, but there were adverts for 'follow-on' milks, bottles, teats, and sterilising equipment.

### Books

Many women also read books: on pregnancy, birth, general baby-care and breastfeeding. Authors of general pregnancy and baby care books included Gordon Bourne (*Pregnancy*, 1975), Miriam Stoppard, Barbara Nash and Penelope Leach. Authors of books on breastfeeding included Doctors Penny and Andrew Stanway (*Breast Is Best*, rev. 1983), Sheila Kitzinger (*The Experience of Breastfeeding*, 1979) and Maire Messenger.

The women usually obtained these books by buying them themselves, or as gifts from relatives and friends. Sometimes they were passed on to the women second-hand by friends or relatives who no longer needed them. Books obtained in this way might therefore be several years old, which can have a bearing on how far natural ideal ideas had gained prominence over the medical model. A few women borrowed books from the public library (again likely to be a few years old) or from the local NCT library.

Women of all social classes read books and found them useful, although those specialising in breastfeeding were the province of the middle-class. Women often said they had difficulty reading ahead since the information did not relate to their experience, but they found it interesting to read up to the stage they were at in pregnancy and a bit beyond, keeping the rest of the book for reference when needed. Some women said they sometimes found details disturbing and thought it best not to read too deeply.

...in *Breast Is Best* there's a *whole* section on things, you know, problems and things that can go wrong. I sort of had a quick flick through that and decided I really didn't want to know all that, and if-, OK, if I got a problem I'd look it up then...things that could happen, sort of like mastitis, blocked ducts, and all sounded rather horrid so I decided I wouldn't actually read those bits in detail. I think too much information is as bad as not enough in some ways (laughs) like that.

(emphasis in original speech)

(Nancy:9:1:4)

The approach in the books devoted to breastfeeding was very much in the mode of the natural ideal. Despite being committed to breastfeeding some women criticised such books for being too extreme and biased, or for being anti-feminist (i.e. assuming a traditional wife-mother role of dedication to the needs of husband and family).

I read the book *Breast Is Best*, which I think is *the* sort of breastfeeding manual, if you like. I find a little bit of it, some of it sort of a bit over the top, sort of the advantages and things. I don't know if they can really prove a lot of it...

(emphasis in original speech)

(Nancy:9:1:2)

(Interviewer: And did you like *Breast Is Best*?)

Um, packed with information, extremely sexist,

patronising. (laughter) I used to read out bits to Melvin, but they were the bits about preparing your husband's dinner in advance, saying 'Don't think you're gonna get this,' you know. (laughter) I thought there was lots of advice about feeding on demand and feeding when you feel the breasts are full even though the baby may not be crying or apparently hungry. So that was very helpful, but I had to ignore the attitude.

(Maureen:11:1:1)

### Conflicting Advice in Written Form

It should be clear by now that bottle-feeding featured extensively in the written materials to which the women were referring. Only in the books dedicated to breastfeeding was it referred to only scantily as a possible temporary alternative in face of problems, the emphasis being heavily on the superiority and achievability of breastfeeding. Otherwise the written materials had two concurrent themes: that breastfeeding was superior, but that bottle-feeding was acceptable and sometimes necessary. Breastfeeding was always presented in the first instance as the ideal feeding method, recommended above artificial feeding. Even advertisements for manufactured baby milks included this message somewhere (as required by the FMF Code). However, the information on bottle-feeding would then present it as a close (even perfect) substitute with advantages of its own, and as a reliable, even necessary, alternative feeding method in case of difficulty. There would be reassurances that babies fed on formula would not be disadvantaged, although there could still be implications of failure on the mother's part.

Breast feeding is certainly best for the health of your baby. These are the reasons.../Some parents have clear reasons for choosing the bottle...If you've got definite reasons for choosing to bottle-feed, don't think of it as second best. The 'best' way to feed your baby is the way that feels right for you. (Health Education Council (1984) *Pregnancy Book: A guide to becoming pregnant, being pregnant and caring for your newborn baby* p.34)

Breast milk is the perfect food and drink for babies. It provides perfect levels of nutrients and it will help protect your baby against many disorders...For these good reasons alone it is sad that very few babies in Britain are fully breast fed even for the recommended four to six months. Most mothers give up before they plan to because they think - usually wrongly - that they can't produce enough milk...(p.10)...Some mothers do not want to feed their baby and others, for work or other reasons, just can't cope with it. There are also mothers who want very much to breastfeed but when it comes to it, just can't manage it for a variety of reasons. Breast milk is not always present in adequate amounts and, as the fat content varies from feed to feed, short of weighing the baby before and after every feed, it is impossible to know exactly how much milk has been taken...No mother who chooses to bottle feed need

worry that her baby will not flourish and thrive. The modern baby milks now available have been modified so that the proportions of protein, carbohydrate, fat and minerals are similar to the levels found in average breast milk. These baby milks can be used from birth, and provide all the nutrients for healthy growth for the first four to six months... (BMA (1984) *You and Your Baby: Stage 2 Birth to Infancy* p.14)

In general these sources recommend breastfeeding for a minimum of four to six months, with the introduction of solid foods after four months although advertisements and leaflets from weaning food manufacturers suggest three to four months.

On the whole the advice reflects the natural ideal approach and recommends flexibility and demand feeding. However, a comparison of leaflets and booklets (distributed free through the health service) and magazines (bought from newsagents) revealed a number of contradictions, often within the same publication, as ideas from the medical model were not fully relinquished. Also, when arguments were presented against the old medical model ideas, mothers themselves or their lay advisers were blamed as the source of out-of-date or mistaken ideas, but the contribution of professional health experts to the establishment of these ideas was not featured. Magazines bought from newsagents were the exception here as they did sometimes feature criticisms of medical attitudes and practice. (In contrast the books on breastfeeding which were read by many middle-class mothers frequently pointed out the shortcomings of medical advice and practice.)

The following are some examples of conflicting advice in the booklets, leaflets



and magazines used by the women in the study.

# 1. How often should the baby be fed?

All the sources recommended flexibility rather than routine, especially in the first few days when it was recognised that breastfed babies would probably make frequent demands. However, there was still an assumption of the normality of feeding at approximately three or four hour intervals, whether this were achieved through the mother's imposition of routine or through the baby naturally settling into such a pattern. The possibility that babies might settle into any other sort of pattern was not suggested (e.g. alternating periods of very frequent feeding with long periods without any demands at all).

Rather than trying to stick to a timetable it is best to feed when your baby wants to be fed. This might be very often at first. Gradually your baby will settle into a routine, probably asking to be fed every two or three hours during the first weeks... (Health Education Council (1984) *Pregnancy Book: A guide to becoming pregnant, being pregnant and caring for your newborn baby* p.68)

There is no need to breast feed your baby strictly by the clock. For the first few days feed him when he seems to want it...but work towards a regular three-four hour schedule as this makes life so much easier for you and it suits the baby too when he gets used to the idea. (BMA (1984) *You and Your Baby: Stage 2 Birth to Infancy* p.11)

The key to survival is to realise that your baby is the boss. Never mind that he's a mere 7½ pound smidgen in white towelling - from now on he's going to rule your life, and the sooner you accept this the easier it will be. This particularly applies to feeding. ...breast-fed babies guzzle on and off all day long to begin with. And that means that no sooner have you put him down to sleep than he's awake again, demanding a quick top-up. ...once you get into full production, so to speak, life settles into a more predictable routine... (*Mother & Baby* (1986) p.34, May)

But the introductory booklet to the hospital recommended a three-to-five hour routine even in the first few days:

The babies are demand fed. However, we recommend that baby should not be left longer than 5 hours without a feed or fed more frequently than 3 hours for the first few days after birth. (North West Surrey Health Authority (no date) *Your Guide to the Maternity Unit*) (This was the information booklet about the hospital at which most of the women in the study had their confinements.)

## 2. How long should a feed last?

Just let your baby decide how long a feed should be. (Health Education Council (1984) *Pregnancy Book: A guide to becoming pregnant, being pregnant and caring for your newborn baby* p.68)

The previously recommended guidelines for length of feeds are included as some mothers (and grandmothers) find difficulty in abandoning the idea of scheduled feeding. However, try to be flexible rather than follow a rigid regular feeding pattern. (Chart follows showing 'Minutes at each Breast' against age of baby, increasing gradually from 2 minutes at 1-2 days to 10-15 minutes at 11 days onwards) (Cow & Gate (Aug. 1985) *Cradle Days* p.6)

There's no need to restrict the number of feeds. But there is not much point in going on for more than 10 minutes on either side as the milk will normally be exhausted by then. Going on longer just tires everyone out. (BMA (1984) *You and Your Baby: Stage 2 Birth to Infancy* p.11)

When the baby sucks, you make milk. Please read that sentence again - *when the baby sucks you make milk*. Your breasts are not two bottles stuck on your chest, they work in a different way. They are not full - then empty. When your baby sucks, you make milk. So that if your baby sucked for 12 hours without stopping, you would be making milk all the time... (Medical Audiovision (3rd issue 1985) *Mother and Child*) (emphasis in original)

### 3. Changing breasts.

Offer one breast for as long as your baby wants, then offer

the other, but don't worry if at first one breast alone seems to be all your baby wants. Just start with the other breast at the next feed. (Health Education Council (1984) *Pregnancy Book: A guide to becoming pregnant, being pregnant and caring for your newborn baby* p.68)

Your baby should be put to both breasts for equal lengths of time at each feed. This will help prevent one side becoming too full and uncomfortable as a result. (Cow & Gate (Aug. 1985) *Cradle Days* p.5)

4. Is there enough milk? (It depends who is telling you there isn't! The literature from a milk manufacturer (below) justifies suggesting the possibility of the inadequacy of the mother's milk by invoking medical authority, whereas the leaflet written by medical professionals presents this as a mistaken belief which is the fault of lay advisers.)

Occasionally a mother may not produce enough milk for her baby and a 'top-up' bottle feed (complementary feed) may be suggested, to give baby a little extra milk. But you should only do this if it is recommended by your clinic or doctor. For top-up feeds, one of the modified, low solute milks should be used and the manufacturer's mixing instructions followed very carefully. (John Wyeth & Brother Ltd. (no date) *Breast Feeding Your Baby*) (brackets in original)

Beware of well-meaning friends or neighbours who tell

you that if your baby is hungry after a feed, this means that you can't make enough milk, or that your milk doesn't suit, or that the milk is too thin! Nonsense, and tell them so. Breast feeding works on a demand and supply principle. When babies are hungry you feed them, and the more often you feed them the more milk you produce. Have confidence in yourself. (B. Edsall & Co. Ltd. (1984) *Breast Feeding* p.17)

5. Does breastfeeding meet all the baby's needs?

Unless specifically ordered by the doctor, babies don't need water, sugar-water or extra cow's milk. Breast milk alone - even the small amounts of colostrum produced in the first few days - is perfect and supplies all the water and food necessary. Any other drinks you give your baby will reduce your milk supply as he will not want to suck so much. (BMA (1984) *You and Your Baby: Stage 2 Birth to Infancy* p.12)

Cow & Gate Pure Juices are suitable for babies from four weeks old. Try offering one during a wakeful spell between feeds. (Cow & Gate advertising leaflet, 1986)

Because breast milk contains all the water your baby needs, you should not need to give him extra drinks in between feeds, but do allow your baby to feed as often as

he wants to so that he doesn't become thirsty or 'dry'.

(John Wyeth & Brother Ltd. (no date) *Breast Feeding Your Baby*)

#### 6. Crying babies.

5th Day:...Any crying after a good feed is more likely to be due to tummy ache than hunger. You can try giving a drink of boiled, cooled water. But more important, cuddle and comfort your baby... (Health Education Council (no date) *How to survive the first week of breast feeding*)

Many babies are particularly hungry on the fifth day...A baby who seems hungry should be fed...Your baby is getting three things at each breast feeding - food, drink and comfort. (B. Edsall & Co. Ltd. (1984) *Breast Feeding* pp.15-16)

Of course, crying doesn't always mean hunger. It might mean a tummy ache, a dirty nappy, loneliness...if you're not sure what's needed, it does no harm to offer a breast. Even if your baby isn't hungry, sucking a little and being close to you will be comforting. (Health Education Council (1984) *Pregnancy Book: A guide to becoming pregnant, being pregnant and caring for your newborn baby* p.68)

Overall, bottle-feeding featured prominently as an alternative to breastfeeding in

most of the literature referred to by the mothers. As with the ante-natal classes, the natural ideal approach seemed to be the main influence, but again there were conflicting ideas reflecting the influence of the medical model. But at this stage the women found it difficult to grasp what they were reading anyway. Basically they felt they could only really learn how to care for a baby and breastfeed through their own practical experience, and that could come only once the baby was born.

### 7.3 CONCLUSION

All the women in the study said they were pleased at the prospect of becoming mothers. However, they also felt uncertain and apprehensive. As first-time mothers they were facing changes in their lives and unknown experiences. There were fears about loss of social status, social contact and income, and also apprehensions about the momentous event of the birth itself. They were trying to prepare themselves for taking on the responsibilities of baby-care, but they were hampered by their lack of familiarity with babies and with the difficulties of trying to learn in abstract ways without opportunities for getting their 'hands on'. Not surprisingly therefore the women saw their hospital stay as a crucial learning time, and looked to the hospital staff to give them the necessary practical guidance once their babies were born.

(Interviewer: So can you think of any other sources of information...?)

Just books and medical staff. But as I said, the medical staff haven't really-. When you're in hospital they're supposed to help you, aren't they? After the baby's born. They have nursery nurses and things like that to help you

along, so I'll be listening to them...

(Ruth:37:1:13)

(Interviewer: So how confident do you feel?)

Um, well, I'll be all right, cos I mean I know they show you everything in the hospital and things like that, so it's just maybe the first (laughs), just the handling little babies...

(Isobel:31:1:11)



**CHAPTER 8: BEFORE BIRTH: INTENTIONS AND EXPECTATIONS**

Despite their lack of knowledge of motherhood, at the first interview virtually all the women had made their decisions as to breast or bottle-feeding. Only Françoise (social class II) gave no definite indication at the first interview. Breastfeeding was by far the more popular choice, with 41 of the 47 women intending to try it. All five who intended to bottle-feed were social class III. Of these, Diana would have chosen breastfeeding but understood that it was not possible because of her treatment for cancer. Lorraine, Fay and Trudie had all given serious consideration to breastfeeding but felt the disadvantages outweighed the attractions, although they did not absolutely rule out the possibility of breastfeeding in hospital especially if they were subjected to pressure by the staff. Only Brenda, who was sceptical about the claimed superiority of breastfeeding, seemed completely confident in her choice of bottle-feeding. Thus, although bottle-feeding was chosen only by working-class women, breastfeeding was by no means only a middle-class choice.

As the women were able to talk freely during the interviews, they considered both pros and cons in explaining their feeding choices. The reasons given by the women before the birth for breastfeeding can be categorised under the following headings: (1) Breastfeeding as a Norm; (2) Benefits to the Baby; (3) Benefits to the Mother. These will be considered in turn together with the counter-arguments and reservations which the women also expressed.

### 8.1 BREASTFEEDING AS A NORM

The fact that breastfeeding was encouraged by health professionals carried a lot of weight. All the women wanted to do the best for their babies, and in general they believed the experts' claims as to the superiority of breast milk over formula, although middle-class women tended to see this as a more pronounced superiority than working-class women. Therefore it was generally accepted that it was right that a mother should at least attempt to breastfeed. For some women, however, there were additional factors which made breastfeeding seem not only right but normal. These were particularly mentioned by middle-class women.

For instance, the middle-class women were more likely to have friends and relatives who breastfed, and to know that at least some of them had been successful. Some of them even knew they had been breastfed themselves.

Amongst my contemporaries my sister-in-law successfully breastfed both her babies, and she's not the most phlegmatic or relaxed of people. I reckon if she can do it (laughs) I'm probably going to do it too. So it's just something I've assumed...

(Valerie:13:1:1)

The working-class women had fewer friends and relatives who had attempted to breastfeed, and hardly ever knew of any who had been successful. However, most of the working-class women who wanted to breastfeed were enthusiastic about it as the up-to-date choice. It was encouraged by the medical profession, they believed it was the best feeding method, and it had become normal to want to try it.

...people encourage you more to breastfeed. I mean I can

remember sort of four or five years ago my friends having their babies, and it was, 'You're going to bottle-feed.' There's now-, all my friends seem to be trying to breastfeed. So I think things have gone more for breastfeeding now...

(Tracey:26:1:1)

But to the working-class women it seemed a difficult process which was not likely to work.

Yes, I'd like to breastfeed. I'd like to give it a try anyway, see how I go from there on, but if I can't breastfeed I've got the bottles just in case...I've got a friend of mine who was adamant she was going to breastfeed, and her baby just wouldn't take it, and I think she stayed in hospital ten days for them to try and get breastfeeding, but it didn't happen for her, so I thought, well, you know, hopefully it'll happen for me.

(Tracey:26:1:1-2)

The middle-class women often said they had been surprised to learn at ante-natal classes of possible breastfeeding difficulties, having previously assumed that something 'natural' would 'come naturally'. At the first interview none of the middle-class women were taking success for granted, but they were far less fatalistic than the working-class. They more frequently expressed themselves 'determined' to 'persevere'. They still saw it as something which should be within the capabilities of nearly all women, and that problems ought therefore to be surmountable.

Obviously there was a general lack of familiarity with breastfeeding for all classes of women, despite it being more of a sub-cultural norm for middle-class women. But then the middle-class women were generally less knowledgeable of all aspects of baby-care, including bottle-feeding. For working-class women, on the other hand, it was not just a case of bottle-feeding being more the sub-cultural norm. They were also more likely to have some familiarity with it, even sometimes to the extent of having their own practical experience of giving occasional bottle-feeds.

But the 'normality' of breastfeeding to the women was not simply a matter of whether other people breastfed or how often were successful. There were also questions of embarrassment or even revulsion connected with breastfeeding being a 'natural' body process. The 'naturalness' of breastfeeding was often viewed positively, especially by middle-class women.

...I've always assumed that I would try and feed it myself.

It's never really crossed my mind that I won't...I rather feel that if we were made to feed them, then if you've got the apparatus to feed them, you might as well try and use it...I mean there's not much point in having breasts in a way. If we weren't meant to feed babies, then we wouldn't have them.

(Audrey:10:1:1)

But all the women were aware of social problems stemming from the 'naturalness' of breastfeeding which were all to do with it being thought socially unacceptable in some way. However, there were variations in their feelings and fears.

Occasionally there were references which suggested that this 'naturalness' could

be a source of revulsion through seeming animal-like or crude. Trudie, for instance, associated it with (to her) less culturally advanced people (Africans), whilst for Irene the idea of expressing milk evoked images of milking cows.

(Interviewer: Have you ever seen anybody breastfeeding, apart from on films?)

Yeh, and I think it's blinkin' embarrassing. I walk out the room. I don't know why. I just...But in Africa, you see films on the telly on Africa and that, and you don't think nothing of it...And you see a film with an English person breastfeeding, and you think, 'Oh!', you know. (laughter)  
(bottle-feeder)

(Trudie:45:1:14)

...the only drawback I suppose is the fact that it's limited completely to you, so that if you're a bit tired, short of this lovely<sup>3</sup> expressing of milk, sounds all a bit like farming to me...

(Irene:3:1:1)

But it was rare for women to admit to feeling this sort of revulsion themselves. Slightly more common were feelings of embarrassment which were not of revulsion so much as a feeling that as a body process breastfeeding was 'personal' and should be kept private. As with going to the toilet, sexual intercourse or nakedness, they seemed to feel that public exposure would involve a loss of dignity. These 'natural' things could be witnessed only in particular circumstances by certain persons (e.g. very close intimates

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<sup>3</sup> Irene was using the word 'lovely' sarcastically.

or specially trusted persons).

I don't like so much the fact that, some people, if you go out and they've got a little baby and they suddenly sort of say, 'Do you mind if I breastfeed?' Well, I wouldn't do it in public. I know one of the girls brought that up in the class and she couldn't understand people being upset about it, but I think it's a very private thing. To me it's still-, perhaps that's very old-fashioned, but it's very private between you, the baby and your husband, but not everybody loves it, you know, some people really think it's quite awful...

(Anneka:5:1:23)

...it still embarrasses me, if a woman started doing it in front of me. I mean I couldn't do it in front of anybody else. My husband, yes, but not anybody else...I still find it a personal thing. They said that at the re-union (antenatal class where expectant mothers meet mothers from a previous course), the midwife said, 'I hope of the mothers suddenly plops one out and starts feeding her baby.' And I thought, 'I hope she doesn't.' (laughter) I mean I don't mind her walking off in the other room.

(brackets added)

(Margaret:24:1:6)

On the whole expressions of feelings of revulsion or of the need for privacy were

associated more with working- and lower middle-class women than upper middle-class.

But the most general problem for the women was fear of other people's embarrassment, revulsion or disapproval. All the women in the study were affected by this to some extent. Sometimes there were fears about their husbands' reactions which suggested a conflict between breastfeeding and the primary cultural definition of breasts in terms of their sexual attractiveness to men. Here Lorraine discusses this question with a friend who has recently had her baby.

Lorraine: I don't know. I think he'd more or less say, 'Don't come out with me,' type thing...He'd more or less say I was exposing myself all the time.

Friend: That's what Phil was thinking about, wasn't it?...He said if I breastfed I wasn't to do it in front of anybody. He didn't want-, he looks at it as a bit sexual, I suppose. Didn't want me to expose myself to other people.

Lorraine: I suppose it is to them. It's more or less we're their wives so we shouldn't be showing any part of our body to somebody else who might be sitting there at the time, even though the baby does need feeding...

(Lorraine:15:1:22-23)

...he was very wary of the fact when I started to leak. You know, he found that very difficult to handle, I think. The idea that suddenly these sort of things weren't what they had been before. They were suddenly a milk

machine, as it were. He found that a little bit hard.

(Andrea:17:1:26)

(See also Chapter 7, pp.127-8 Hilary:1:1:9-10 and Fay:21:1:8.) There were also some examples of women feeling that some of their relatives or friends were hostile (see Chapter 7, p.129, Priscilla:18:1:1-2 and Fern:39:1:4.)

Again, fears of hostile feelings from husbands, relatives or friends were associated more with working-class and lower middle-class women.

But all women assumed at least some restrictions on feeding in public because of the possibility of causing embarrassment to others. Middle-class women seemed to expect less restriction because they foresaw more tolerance amongst their own acquaintances (or felt less embarrassment themselves with their own acquaintances). But, even so, all the women foresaw difficulties in at least some social settings, such as very public places like shopping areas or restaurants, or where people of slight acquaintance were present. Some people were viewed as more susceptible to embarrassment than others, e.g. men rather than women, older people rather than younger, unmarried rather than married. The women often also expressed fears about the lack of facilities in public places for retiring for public view to breastfeed.

One thing that does worry me is if you do want to go out, for example, and you're breastfeeding, there aren't many provisions. I think we're quite bad in this country. There's nowhere much and it's almost frowned upon. A case the other day where a person got turned out of a restaurant or whatnot. Even if you do it discreetly, somehow people don't seem to like it...A friend's house is



different, a good friend or relatives, parents, I wouldn't mind so much, but I think the reason I'd feel embarrassed is because of the attitude people have to it. I'd feel people were sort of staring at me. You know, 'What on earth's *she* doing?' It's not the done thing exactly, and although I've read about people doing it very discreetly I would still feel that people were looking at me...

(Hilary:1:1:5)

In the late summer we went out to a few barbecues and things, and a lot of people brought their children with them, and two people had two new-borns with them, or a couple of weeks old, and they had no problem. I mean they just brought them with them, and then when they fed them they went upstairs. Lovely, you know, it made it sort of nice because I thought, 'Oh well, you have a little one, doesn't mean that you can't go out.' People accept that now, that you can bring your little one with you.

(Anneka:5:1:24)

It's all right if you're going around to somebody you know, but if you're going round to somebody's, like a friend, and you're going round to their home or something but they're not over-close friends, I'd feel too embarrassed to ask, 'Can I go and sit in your bedroom for five minutes?' I think even around my mum's place, I'd be so

dead embarrassed I'd have to go and hide in my old bedroom or something...

(Lorraine:15:1:21)

Well, I mean, sort of like if you go out for the day somewhere, if you go to, I don't know, if you sort of go to the zoo or something for the day, I mean there's not many-. You've got to keep feeding it every so often, haven't you? So. Obviously you can't sort of sit out in the park and feed it really... Obviously you could give them a bottle, on the beach or whatever.

(Isobel:31:1:13-14)

In the following quote the woman is explicitly saying that the need to keep breastfeeding hidden is not because of her own personal embarrassment and need for privacy.

Well, say, like my husband's friends...They come round.

Not that I would be embarrassed, but I think they might think oooh...

(Barbie:30:1:38)

In conclusion, although attempting to breastfeed was a sub-cultural norm for middle-class women, it was not something they were familiar with, and they did not rule out the possibility of failure. It was becoming normal for working-class women to attempt to breastfeed, but they were more familiar with bottle-feeding, and did not expect breastfeeding to work. Also, despite belief that it was right to breastfeed, all the women had at least some sense of the social unacceptability of breastfeeding. Altogether then, it cannot be said for any of the women that breastfeeding had the status of a social norm

to the extent that bottle-feeding seemed deviant. In fact, in public it was breastfeeding which had the status of deviant activity, a problem which some of the women of all social classes thought they could solve by converting breastfeeding into bottle-feeding through expressing their milk (see section 8.3.3).

## 8.2 BENEFITS TO THE BABY

All the women could recount several ways in which breastfeeding was thought to be better for a new baby than formula: it was superior nutritionally; it conferred immunities and protected against stomach upset and diarrhoea; it protected against the development of allergies; there was no risk of bacterial contamination; it was always the right temperature and mix; and it would not lead to obesity.

Well, I mean it's everything there for your baby, isn't it?

I mean it's exactly made up for the baby in the right sort of ways and everything, isn't it?...I mean if you buy powdered milk, not all of them will suit your baby, but your breast milk should theoretically, shouldn't it?

(Gaynor:32:1:1)

I think that's the main thing, the fact that it's supposed to guard the baby against all sorts of infections more than bottle-feeding.

(Tabitha:4:1:4)

I'm an eczema baby, and my husband has asthma and eczema on his side too, he had eczema a bit when he was a baby, so obviously breastfeeding would be far better, is far better for eczema babies, and I'm concerned that

obviously I might have a baby that's allergic to cow's milk.

(Vanessa:12:1:3)

Well, they say that it'll stop it-, it'll prevent it getting over-weight...

(Milly:33:1:1)

Some women also mentioned the psychological benefits of a process which encouraged 'bonding'.

However, the women regarded manufactured baby milks as high quality products, scientifically formulated to meet the baby's needs, and reliable. They were also conscious of evidence of babies thriving on artificial feeding.

...although breast milk is better in the way that, you know, it gives better resistance to the baby, I still believe that powder milk is very good. It's got the right dosage of everything and vitamins, and, as I say, I've seen babies being brought up on powder milk and they're all right.

(Françoise:43:1:20)

...right really from the minute I found out I was pregnant I decided (to breastfeed), basically because I think it gives a baby a good start. I think if you can give it the immunities, and everything else that it needs, I think it's-, and I think it brings you closer to the baby as well first off. But saying that, I was bottle-fed, my brother was bottle-fed, and we are very close to my parents, so you

don't really know, do you?

(brackets added)

(Tracey:26:1:11)

All the women saw formula foods as suitable substitutes for breast milk. Upper middle-class women and some lower middle-class women tended to emphasise the superiority of breastfeeding more, but even they regarded formula milks as a good standby in case of breastfeeding difficulties, and bought bottle-feeding equipment in readiness. This was further justified as the women believed they needed the means to give drinks of water or fruit juice to their babies. So it was normal to invest in bottle-feeding equipment despite the intention to breastfeed. Only one woman reported that she had not acquired such equipment, and this was a conscious decision to deviate from the norm.

...having bought feeding bras, and *not* having bought bottles in the hope that I won't need them for the immediate future...hopefully positive thinking works, and if you want to breastfeed badly enough-.

(emphasis in original speech)

(Irene:3:1:13)

Although the women believed successful breastfeeding provided the ideal feeding method in theory, in practice they feared that as individuals they might not attain that ideal. There were all sorts of problems which could beset the mother and render her milk inadequate compared to formula. The women indicated that in general they had received the message that supply equals demand, and that insufficient milk can be solved by feeding more often, and yet they did not seem to have much confidence in this idea.

They were too aware of people having to give up because of insufficient milk, and their bodies seemed too vulnerable to upset to seem reliable.

...getting tired and not having enough milk. That's really my only fear, cos I'm sure that's bound to happen at some stage.

(Valerie:13:1:17)

Again, breastfeeding seems to depend so much on one's mood, and whether I shall be able to relax sufficiently even in private, far less in public, is slightly bothering me...

(Irene:3:1:11)

Whereas middle-class women feared milk insufficiency, for some working-class women it was more like an expectation.

The measurability of formula had a lot of appeal, particularly for working-class women.

...I think another thing that puts me off about breastfeeding, I'd always be worried that they weren't getting enough. Now with a bottle, you've got the bottle and when it's empty, it's empty, and you know they've drunk it or whatever, you know.

(Fay:21:1:7)

Another way in which the women felt their milk was vulnerable was that they might inadvertently contaminate it. Although they saw breast milk as free from bacterial contamination, they were learning of other dangers.

...one of the midwives...said to me, 'Oh, are you going to breastfeed?' And I said, 'Well, yes, if I can.' So she said, 'Well, what about these tablets you take?' So I said, 'Well?' So she said, 'Well, they might come through and might affect the baby.' She said, 'Have you thought about that?'...

(Stella:29:1:11)

One of the things that worried me a bit, being a vegetarian, was when the midwife was giving us instruction about diet and breastfeeding, and she said, 'Don't eat-, avoid onions, bananas, spicy foods,' and all this sort of thing, and they're all my staple diet, you know. I eat a lot of bananas and onions and fruit and things, and that was a bit worrying...cos it does funny things to the baby, I suppose. So that was a bit sad.

(Ruth:34:1:19)

Altogether then, although the women believed in breastfeeding as an ideal, in practice the fact that it depended on the natural functioning of their own bodies made it seem unreliable and unpredictable. Formula milks, in comparison, were viewed as perfectly adequate foods for babies which also offered greater reliability and measurability. These feelings were expressed by all social classes, although the middle-class women seemed less reconciled in advance to the possibility of not being able to produce sufficient or suitable milk for their babies. They were more inclined to see breastfeeding as something which ought to be possible for virtually all women, and so

if they could not manage it, it would seem more of a personal failing i.e. the result of mistakes they had made or their not being relaxed enough rather than a malfunction in their lactating function, although with their higher expectation of success the latter would also be disappointing to them. But what was frustrating to these women was that as inexperienced and unknowledgeable mothers they feared being unable to prevent these failings.

The working-class women were helped in their acceptance of early failure by a belief that most of the benefits from breastfeeding were conferred while the baby was still tiny, and that the advantages over breastfeeding would rapidly diminish. This was reflected in an expression often used by working-class women but not used by the middle-class, i.e. giving the baby 'a good start'. They wanted to do their best for their babies, but with breastfeeding this was achieved mainly in the first few weeks after birth. With bottle-feeding as more of a sub-cultural norm, they tended to see any breastfeeding as a bonus rather than the baby being disadvantaged by formula feeding, and so just a few days of breast milk was seen as having conferred benefit on the baby even though the mother might not be able to meet her baby's continuing needs.

### 8.3 BENEFITS TO THE MOTHER

#### 8.3.1 Physical

Although the women had a general idea that doing something 'natural' must be healthy, mention of any direct health benefits to themselves was rare and vague.

...I think probably it helps to settle your hormones better.

Ah, I've no experience. I'm just going on what I've read and what I've been told. But I think it probably does help your body to settle down better after the pregnancy and



birth.

(Sarah:2:1:1)

One woman thought that breastfeeding would protect against breast cancer in the long term.

But one specific physical benefit was frequently mentioned, and seems to have featured at all the ante-natal classes, although the benefit was seen more in terms of cultural images of femininity than of health. This was that breastfeeding would help restore a slim, pre-pregnancy type figure. Against this advantage, however, could be set the idea that while breastfeeding a mother would not have the freedom to manipulate her own body for herself by dieting and exercise.

...I think it's quite well known that if you breastfeed then the uterus contracts so therefore you should lose weight quicker, but other people say, no, no, if you don't breastfeed then you can regain your own body-weight because then you can diet and you can do all the other things which you really shouldn't do if you were breastfeeding.

(Connie:23:1:7)

Also, there could be some risks to one's figure from breastfeeding.

...(my friend) blames not feeding the baby herself on the shape of her breasts now, because she didn't wean the baby off, she just cut off completely, and she blames that, because she cut off completely, she hasn't got particularly attractive breasts now. So I've taken that in and taken due

consideration of that fact...it's something that I have read that you should wean the baby off yourself gradually rather than stopping completely because of engorged breasts and goodness knows what else, so maybe she has got a point.  
(brackets added)

(Sheena:6:1:10-11)

If I can go without my bra I will...About the feeding side of things, because all the books say you must wear a bra or else you'll droop, and I'd much rather go without, much, much rather go without. They emphasise the fact that there aren't any muscles as such to support the bust, and with the extra weight of the milk, then obviously it's going to come down on to the tissues. And thinking about my grandmother who fed six babies and never wore a bra, I remember seeing her in the bath, she was flat and then sort of-, you know. So I wouldn't want that to happen...

(Andrea:17:1:29)

Also, other aspects of breastfeeding ran counter to cultural images of feminine attractiveness, e.g. over-enlarged breasts with distended veins, leaking, substantial and unglamorous bras, and having to restrict one's clothing to allow front opening.

I must admit the film tended to put me off. Just purely from the point of view of seeing women with these

enormous boobs and-, looked like an RAC road-map, that was all I could compare it to, and I thought, 'Oh, dear.'

(Cynthia:14:1:6)

I didn't like the look of the NCT ones (bras) with laces down the back. No. For me, I mean. Some people obviously need that, but I don't, not at the moment...They're a bit of armour. (brackets added)

(Hilary:1:1:14)

...they tended to show women with large breasts on the film, that looked very full and very droopy, and I suppose if you were young and had a good figure, if you were seeing that film and you looked at that, you thought-, you'd immediately associate that with breastfeeding, you'd think, 'Ooh, I don't want to breastfeed.'

(Vanessa:12:1:16-17)

In the above quote an upper middle-class woman is associating this reaction with the younger woman. That the upper middle-class women showed less concern for presenting conventional images of femininity could be associated with a greater self-confidence through their maturity (they were all over 25) and their personal achievements in other areas (in particular, careers and education).

As far as health impairments from breastfeeding are concerned, between them the women feared quite a catalogue of minor health hazards and physical discomforts.

...one girl I spoke to, she was only in hospital for two days and her breast became engorged and she then couldn't

feed for a week, so ever since she told me about that, I've been thinking, 'Oh, bet I get engorged breasts'...

(Vanessa:12:1:26)

I'm dreading the cracked nipple syndrome I must admit.

(Connie:23:1:9)

...my husband's brother's wife had to give up after about four weeks I think because she had a cyst in her breast which she had to actually have an operation to remove, and then she developed one in the other breast as well. Luckily the other one just went of its own accord but she was told she had to stop breastfeeding, otherwise it wouldn't go. And also, my mother-in-law had that as well when she was feeding my husband...

(Tabitha:4:1:15)

...I've heard of various other problems, you know, with abscesses and all sorts of things...

(Brenda:25:1:1)

My cousin who breastfed was-, she complained that it made her very, very tired indeed...

(Connie:23:1:6)

...one girl there had tried breastfeeding, desperately wanted to, and couldn't. Well, she tried it for about fourteen weeks and got in a right state...it was just very, very painful, and the more painful it was the more tense

she was. The more tense she was, the vicious circle.

(Pamela:16:1:2)

### 8.3.2 Personal Satisfaction

Nearly all the women who intended to breastfeed expected to gain personal satisfaction from it. There was a strong desire to do the best for their babies, to be good mothers, and this included breastfeeding. But the closer physical contact and subsequent emotional closeness were also anticipated with pleasure.

I think it was something I always wanted to do right from the start. I didn't know that much about it and didn't realise how good it was for the baby. The only thing, the first thing I wanted was contact with the baby, and I thought you got that far more through breastfeeding, so even if there hadn't been that much difference between, say, the nutrients of breast milk and cow's milk, I would have done it because...I want the contact with the baby.

(Vanessa:12:1:1)

...the thing that appeals to me I suppose about breastfeeding is the sort of close contact, and something I hadn't realised before was that the baby's vision is just about the eye contact when you are feeding. So yes, I think I'll enjoy that.

(Nancy:9:1:23)

These feelings were characteristic of all social classes. In fact, all the intending bottle-feeders except Brenda had experienced some temptation to breastfeed through wanting

to do the best for their babies and because of the promise of feeling closer to the baby.

A few middle-class women also mentioned a feeling of not wanting to miss the opportunity of a unique female experience, and also of wanting the satisfaction of proving themselves capable of performing a natural function.

...I've thought, well assumed right from the start I was going to breastfeed it because it may be the only chance you get to actually have a go at breastfeeding. Bottle-feeding you can always feed somebody else's baby so it's my chance to have a go and see what it's like.

(Pamela:16:1:1)

However, the potential satisfaction of demonstrating a unique female ability was not strongly expressed. In fact, in this context the women sometimes expressed fears that their monopoly over breastfeeding would deny the right of their husbands to share feeding (see Chapter 7). Bottle-feeding was seen as a solution to this.

...also wanting to give my husband a-, a bite at the cherry, if you like.

(Interviewer: Has he said then that he'd like to feed the baby?)

I'm sure he would, yes. He's very into children. I think he might feel a bit-, not left out, but he'd like to have a go, so come to some arrangement expressing some, or a bottle or something every now and then, so he can.

(Pamela:16:1:7)

Against the expectation of personal satisfaction from breastfeeding could also be

set the feelings of revulsion a few women expressed (see above p.162). This was associated more with working-class women, although it was not common and was not strongly expressed by those intending to breastfeed. Revulsion at the idea of feeding an older baby, over a year old, was expressed more forcibly, though, by some working- and lower middle-class women, and a number of women who were happy to breastfeed were revolted by the idea of expressing (see above, p.162).

Only one woman, a self-proclaimed feminist, associated breastfeeding with sexuality and wondered whether she would experience feelings of sexual pleasure. This is something that had not apparently occurred to the other women. Breasts were a sexual attraction to men, or a source of pleasure to themselves only through sexual relations with men. Giving birth and breastfeeding were seen as non-sexual processes despite the involvement of sexual organs, and in fact one of the fears about pregnancy, giving birth and breastfeeding was that these processes would repel their husbands or make them seem less attractive in terms of cultural images of femininity. This fear was associated more with working- and lower middle-class women.

### 8.3.3 An Easier Life?

There was a great deal of talk about the ways in which breastfeeding could make life easier for the mother than bottle-feeding. There would be no need for measuring and mixing the feed, or washing and sterilising equipment; breast milk would always be instantly available at the right temperature; and when going out there would be no special equipment to take.

The saving on expense in not having to buy formula was seldom mentioned, and when it was it was nearly always by middle-class women. Those who wanted to bottle-feed were amongst the least affluent, but to them the cost of formula did not seem to be

an issue.

Against the idea of breastfeeding being easier was set a multiplicity of ways in which it could be a nuisance. The social taboo would cause inconvenience and disrupt a normal social life; the mother would be tied to the baby and unable to pass the feeding over to anyone else; and several women expected it to be more time-consuming because the baby would need to be fed more often.

Depending on which point of view. It'd be easier to breastfeed cos you haven't got to muck about with the bottles and changing the water and all that. But then again when you think about convenience-wise, you can leave somebody else to feed your baby if you want to, say, go down the shops, or if you wanted to have a rest or something, a lie-in, and like if you want to send it to your mum for a weekend.

(Lorraine:15:1:19)

I mean the only thing they (ante-natal class) said really that was sort of against it was that only you could do it, and also often your baby needed feeding more often, cos the milk's obviously, you know, very easily digested so the baby gets hungry more often, which obviously means you have to get up more often in the night and things...

(brackets added)

(Gaynor:32:1:4)

I suppose the main one is not being the right place at the



right time. I mean, being out or something like that...we're moving, or going to be moving, possibly about the time it's born, so there's going to be lots of things we're going to want, like looking for carpets and things like that...It's going to be quite hard to do it in sort of an hour or something...

(Pamela:16:1:8)

These sorts of difficulties were mentioned by all social classes, but talking of them as matters of real concern was associated more with working- and lower middle-class women. Working-class women seemed to see most clearly the time-consuming implications of breastfeeding on demand.

Several women thought that the problem of feeding in public, and the burden of being the only one able to feed the baby, could be eased by expressing milk for feeding by bottle. This possibility was featured in ante-natal classes and reading material, and some women were also aware that expressed milk could be stored in the freezer. However, as has been said, some women reacted with revulsion to the idea of expressing milk.

The women overwhelmingly took on board that they would have to find ways of managing feeding to avoid the problem of social unacceptability. Women of all classes expressed disapproval of causing any sort of social disruption through breastfeeding.

My policy is, well, if I do breastfeed, if it is a case where I've got no alternative but to breastfeed in public, I'll make sure I don't make a big thing about it, because a lot of women do tend to make a big hassle of-, 'got to feed

the baby' type thing, but I think it's best to be discreet, rather than embarrass people.

(Sheena:6:1:21)

I'd much rather feed in the car park than make a fuss in Sainsbury's and say, 'My baby is hungry, I must feed it'...I think some people like to make a point. I mean I see nothing wrong with feeding in public if that's what you want to do, and I do think that these people who make a fuss and object to it are being rather silly, but by the same token there's really no need to make a complete fuss and insist on doing it either.

(Valerie:13:1:19)

Despite these implications that other women often flouted breastfeeding norms in public, only one woman in the study (the feminist) actually anticipated asserting her right to breastfeed anywhere she chose by challenging public attitudes.

I think what I feel sometimes is probably I shall get quite aggressive because I think you should be able to just feed where you want, and it makes me very angry that there are restrictions or people look at you all tut and don't think it's quite nice. And when I'm in particular moods I start to say, 'Right, I'm going to go to the most-, the place where people would be most disapproving, and do it.' You know, confront them with it. What it'll actually be like when it comes down to it, you know, unbuttoning your

blouse and getting on with it, I don't know because I can get very militant and then very embarrassed at the same time. Yes, I shall probably sit there very red but feeding.

(Maureen:11:1:17)

But even she thought there would be times when she would respect other people's feelings. In this case asserting her right to feed in front of strangers would be easier than in front of friends in her own home.

I wouldn't want to put people in a position too much, like friends and relatives, where they felt embarrassed, so I'd ask them, or say, 'I'm now going to feed, hope you don't mind.' Just give them the option of finding something else to do, or leaving if it was um-. Yeh, I think I might go out the room if it was several people there who I thought might be embarrassed.

(Maureen:11:1:18)

In general all the women wanted to get back to as 'normal' a life after the birth as possible. A bodily process which required special attention to diet, extra rest, special clothes and which restricted one socially, seemed to prolong the limbo state they were already experiencing with pregnancy. In this respect the hospital represented a safe haven, an environment geared to the needs of the mothers and isolated from the pressures and distractions of everyday life. It is interesting that three of the women who wanted to bottle-feed did contemplate the possibility of breastfeeding in hospital so long as they could revert to bottle-feeding as soon as they left. But then there was the fear that the baby might resist the change.

But I think I might breastfeed while I'm in hospital, cos...while you're in hospital you don't have to go out, so there's not the case of having to feed the baby while you're out in public places. Cos you're in hospital, so I think you might as well breastfeed it if you're in hospital, and then bottle-feed it when you come home. Then again there's the possibility that you're stuck with it.

(Fay:21:1:30)

Working-class women seemed to feel the need to 'get back to normal' more urgently than middle-class, or at least seemed to have clearer ideas of how their lives should be as mothers. There was a general vagueness about how long one breastfed for as the women found it difficult to look beyond the actual birth and the new-born baby stage, but indications of an assumption or a desire that breastfeeding should not extend beyond a few weeks were more prevalent amongst the working-class women. Four middle-class women (Connie, Françoise, Anneka and Andrea) and one working-class (Donna) had definite plans for going back to work and assumed their babies would be bottle-fed by that time, but for only two middle-class women and the working-class woman would this be before the recommended minimum of four months for breastfeeding anyway.

On balance, the women's main expectations of benefits for themselves from breastfeeding were in terms of emotional rewards: the satisfaction of doing the best for their babies, of demonstrating their physical capabilities and from an enhanced emotional relationship with the baby.<sup>1</sup> Physically the women seemed to fear risks to their health more than expect benefits, and arguments about the convenience of breastfeeding because

it necessitated no special equipment or preparation were offset by the inconveniences resulting from the cultural unacceptability of breastfeeding, being more tied to the baby, and the expectation that breastfed babies would need to be fed more often. The disruption of 'normal' life caused by breastfeeding (or by battling with breastfeeding problems) seemed to weigh more heavily with working- than middle-class women.

#### 8.4 CONCLUSION

Only six women in the study were not committed to attempting breastfeeding at the pre-natal interview. Of these one would have chosen breastfeeding if she had felt her illness allowed the choice, and another was undecided. Only four had chosen bottle-feeding, and they can therefore be seen as exceptions. Although it should be remembered that working-class women (who are less likely to breastfeed) are under-represented in this sample, even in this small working-class sample these intending bottle-feeders were exceptions.

On the other hand, bottle-feeding was firmly established in the women's minds as a normal and useful feeding method. It was the more familiar method, especially to working-class women, and it was featured as an efficient feeding method in NHS ante-natal classes and advice literature. All the women saw manufactured milks as high quality products formulated to meet babies' needs, and therefore as adequate, reliable substitutes. Lacking confidence in their breastfeeding abilities, the women regarded bottle-feeding as a necessary safety net in case of emergency. Bottle-feeding was also seen as the means to make breastfeeding manageable, as it would allow other people to give feeds or provide a more socially acceptable method of feeding in public. Even dedicated breastfeeders therefore contemplated compromises with bottle-feeding, either with the occasional bottle-feed or by expressing their own milk to be fed by bottle. This

latter solution was often suggested to the women through their ante-natal classes or advice literature.

However, there was potential conflict here with the advice that feeding by bottle could put breastfeeding at risk through diminishing the mother's milk supply or through accustoming the baby to feeding through a teat. Three mothers who contemplated regular compromises with bottle-feeding therefore ran into opposition from their expert advisers, but only one of them had the knowledge to be able to plan her course of action. For instance, Fenella was worried about broken nights because of her history of insomnia, and so she wanted her husband to give formula-feeds at night on a regular basis, but she felt her suggestion had been merely dismissed by her health visitor and that she was being given the choice of either breast or bottle-feeding, but not both. Hilary wanted to give one bottle-feed per day, as her sister had done, to accustom her baby to taking a bottle when in public or if it had to be left with a sitter. But she understood the risk of bottle-feeding diminishing the mother's supply, and weighed this up for herself with the knowledge that her sister had successfully combined breast and bottle-feeding. Françoise, who was reluctant to breastfeed, contemplated expressing her milk to avoid having to put the baby directly to her breast. She too felt that her idea had been dismissed without explanation, and that she was given a straight choice between breast and bottle-feeding, which left her undecided.

Another way of coping with the inconveniences associated with breastfeeding was to limit it to a few weeks and then change to bottle-feeding, which was an option considered more by working-class women than middle, on the assumption that most of the benefits from breastfeeding were conferred in the first few weeks.

Altogether then, despite the overwhelming popularity of breastfeeding, bottle-

feeding figured prominently in the women's anticipations.

But in general the women did not have clear ideas of what feeding and looking after their babies would be like. They were approaching motherhood as to unknown territory, and they looked to the hospital to provide enough guidance in the first few days after birth to equip them to be able to take on the responsibilities of baby-care in their own homes. Nevertheless the women were not very confident about going into hospital. Apart from their apprehensions about the actual birth (i.e. how they themselves would perform, whether there would be complications, and whether the medical staff would manage the birth according to their wishes), they were having to go away from their familiar surroundings and usual supporters to unfamiliar territory controlled by strangers. Also, some of the middle-class women feared conflict between medical model and ideal type approaches to breastfeeding, and were anxious that the hospital might impose routines and practices which would hinder the establishment of breastfeeding, in particular unnecessary bottle-feeds.

All in all then, the women were not approaching motherhood with great confidence. Their own lack of knowledge made them anxious, and they were not able to gain confidence from the sources of information and help which were available to them.

## **CHAPTER 9: HOSPITALISED INITIATION TO MOTHERHOOD AND BREASTFEEDING**

In *The First Months of Motherhood* Graham & McKee (1979) identify two critical phases when mothers are most likely to give up breastfeeding. One is the period of hospital stay immediately after the birth, and the other is the first few days after returning home from hospital (p.96). In my study, too, these two periods stand out as times of particular difficulty for mothers.

The length of hospital stay after giving birth varied between three and eleven days, the mean being six days. Of the forty-one women who began breastfeeding, seven gave up completely before leaving hospital. But all the women experienced at least some difficulties, and it was common for women to have times when they seriously doubted whether they would be able to continue breastfeeding. As in Graham and McKee's study (1979, pp.15-16), a number of 'inter-related and mutually reinforcing' factors often resulted in a point of crisis or despair.

The women were coming to baby-care and breastfeeding as to unknown territory. At home the new mothers would have to take on the responsibility of caring for and feeding their babies without expert supervision. This is what the women wanted to achieve, but their lack of knowledge forced them to look on the hospital stay as a time when they would be able to learn the basics under expert guidance. For the hospital's part it was policy to encourage breastfeeding and to give mothers the help they needed to establish a confident breastfeeding relationship. However, from the women's descriptions at the second interview, the hospital stay emerges as a time of confusion and anxiety for the new mothers, involving a number of factors which could be expected to hinder a novice's attempts to establish independent breastfeeding.



## 9.1 GENERAL OBSTACLES TO SELF-CONFIDENCE

### 9.1.1 Mother's Physical Condition

The women were having their first introduction to their babies and breastfeeding at a time when they were also undergoing physiological changes and recovering from injuries resulting from the process of giving birth and the application of birth technology. Delivering vaginally, whether 'normally' or by forceps, seemed inevitably to involve some stitching and bruising to the perineum resulting in varying degrees of soreness. Ten women (over 20%) were delivered by Caesarean section, a major operation resulting in about two days confined to bed in a single room attached to an intravenous drip and heavily drugged with pain-killers before transfer to the main ward. Other problems variously mentioned by all the women included: feeling shocked, dazed or emotionally numb; fatigue; over-excitability and sleeplessness; weepiness; infected stitches; diarrhoea; constipation; piles; having to pass water by catheter; anaemia sometimes requiring blood transfusions; retained placenta; after-pains; back-ache; urinary tract infection; raised temperature and feverishness; raised blood pressure; and side effects from spinal block analgesia which included severe headache and dizziness and being confined to bed for several days with intravenous drip (see table 9.1).

In addition there were physical discomforts directly associated with breastfeeding: sore, cracked or bleeding nipples, painfully engorged breasts sometimes accompanied by raised temperature and feverishness; and pain whilst actually feeding which the women had difficulty explaining but which, from their descriptions, sounded like the result of either faulty latching on to the nipple or a strong let-down reflex (See tables 9.1 and 9.3). For most of the women breastfeeding at this time was something of a physical endurance test.

**TABLE 9.1: CATEGORIZATION OF MOTHERS' PHYSICAL DIFFICULTIES MENTIONED IN MOTHERS' ACCOUNTS OF THEIR HOSPITAL STAY - BOTH BREAST AND BOTTLE-FEEDING MOTHERS**

<u>Category</u>	<u>No. of women</u>
Injuries to perineum: stitches/episiotomy/bruising/soreness etc.	38
Caesarean section	10
Painful or uncomfortable engorgement	14
shocked/dazed	5
anaemia	4
blood transfusion	3
over-excitability/can't relax/insomnia	3
weepiness/'blues'	3
infected stitches (perineum or Caesarean)	3
raised temperature/feverishness	3
constipation	2
'piles'	1
diarrhoea	1
urinary tract infection	1
raised blood pressure	2
retained placenta/suspected retained placenta	2
catheter	2
intravenous drip (other than Caesarean)	2
'after-pains'	1
back-ache	1
fatigue	1
side effects from epidural	1
Total number of women	47

NB (1) It was common for women to have more than one complaint.

NB (2) These data were collected by women mentioning them in the course of conversation, and were not asked for systematically. They may well under-represent the actual occurrence of some complaints.

**TABLE 9.2: CATEGORIZATION OF BABIES' HEALTH PROBLEMS PERCEIVED BY THEIR MOTHERS AND MENTIONED BY THEM IN THEIR ACCOUNTS OF THEIR HOSPITAL STAY -BOTH BREAST AND BOTTLE-FEEDING MOTHERS**

<u>Category</u>	<u>No. of Babies</u>
jaundice requiring photo-therapy	3
jaundice not requiring photo-therapy	8
worrying weight loss/inadequate weight gain	4
mucus - cleared by baby's vomit	4
mucus - cleared by stomach pump	2
unexplained vomiting	2
vomiting and not passing meconium (suspected blockage)	1
'tummy upset'/'windy'/diarrhoea	4
'headache' following birth	4
sticky/swollen eye	3
raised temperature	1
urinary tract infection	1
'split' lip	1
admitted to special care baby unit	3
<b>Total number of babies</b>	<b>47</b>

**NB** Babies could have more than one complaint.

TABLE 9.3: CATEGORIZATION OF BREASTFEEDING PROBLEMS MENTIONED IN MOTHERS' ACCOUNTS OF THEIR HOSPITAL STAY

<u>Category</u>	<u>No. of Women</u>
sore/cracked/bleeding nipples and pain when feeding	17
baby won't feed/latch on/ too sleepy	30
baby fretful/won't settle/ seems hungry	9
fears of milk insufficiency (not counting beliefs in the inadequacy of colostrum)	8
baby's weight loss too great/ inadequate weight gain	3
problems caused by engorgement (other than pain for mother)	5
Total number attempting to breastfeed	42

NB (1) It was usual for mothers to experience more than one problem.

NB (2) Some of these categories overlap, e.g. a baby's fretfulness usually led a mother to doubt the sufficiency of her milk; the main feeding problem caused by engorgement was flattening of the nipple causing latching on difficulties.

...my nipples were getting very, very sore. I had white blisters on the end of them...and they said, 'Are you using the cream?', I said, 'Yes,' and they said, 'Well, you'd better try a shield,' and they gave me a shield...But it was absolutely marvellous, the shield. Without that we wouldn't have got as far as we did. Cos as I say, for the first three weeks it was painful, and I honestly didn't enjoy

it, and I thought, 'How do people enjoy breastfeeding?'

(Vanessa:12:2:5,9)

It was as if I'd been bitten. A biting sensation. I thought she'd been born with teeth or something. Acute pain. Acute biting pain...I mean at first it was surprise and shock, and then that sensation continued for several feeds. You know, for several days, and it became quite unpleasant...on the fifth day...my bosoms were like rocks. They were really, really hard, and I was doing the old hot baths and things to try and relieve them...and I was extremely uncomfortable at that stage. I mean, I was quite hating the idea of breastfeeding (laughs). What with the biting sensation when she locked on, and what with them being so very hard and full, and it got to the stage where I couldn't actually raise my arms above my head. They were really very, very hard.

(Connie:23:2:11)

### 9.1.2 Who Is In Control?

Whereas twenty years ago it would have been common in hospitals for babies and their mothers to be separated at birth and brought together only for brief feeding sessions at fixed intervals, changes since then which have made hospital routines more compatible with the natural ideal, mean that mothers now have far more freedom to get to know their babies, to practise handling them, and to feel they are actively taking on the responsibility for their care and feeding.

Many of the mothers in the study had their first attempt at breastfeeding in the delivery room very soon after giving birth. On the post-natal wards the babies' cots were routinely placed all day at the foot of their mothers' beds, and the mothers cared for their babies and fed them 'on demand'. At night the babies were kept in a nearby nursery, and when they awoke the mothers were called by the staff to come and feed them.

Nevertheless, the medicalised institutionalised setting in many ways still cast the women in a passive, dependent role. The experience of medicalised ante-natal care and childbirth had accustomed the women to being managed by professionals. As pregnant women their responsibility consisted of following instructions and submitting to tests and treatments. The actual birth was a particularly closely supervised affair, but the relationship with the staff after the birth became more ambiguous. The women were not prepared for a sudden transition from passive dependence to a more active responsibility.

...they actually left me in the delivery room for the whole of that night, so, she was there with me, and they put her by the bed...I suppose it was about one o'clock in the morning, one of the nurses came in and said, 'Have you fed her yet?' And I said, 'No, no, don't know what to do.'...So the nurse got her out of the cot, sat me in the chair, latched her on, and disappeared...She was quite happy to suck. But the thing I found was that nobody said to me, 'Right, she's yours, feed her when you want.' And I was waiting for the nurses to say, 'Right, time to feed.' And it wasn't until I actually got down to the ward

downstairs and people were sort of picking up their babies  
and feeding them that I thought, 'Oh. Mmm.'

(Andrea:17:2:4-5)

But the mothers still did not have much responsibility. The physical condition of both mothers and babies remained the business of the staff who made the ruling decisions in these matters. Judgements about the mother's physical condition sometimes resulted in nurses taking over the tasks of baby-care, including sometimes artificial feeding. Judgements about the baby's physical condition sometimes resulted in separation of mother and baby while the baby was treated in another room on the ward or transferred to the Special Care Baby Unit (see Table 9.2).

Although life on the wards was fairly relaxed compared to past regimentation, the institutionalised setting still had its own routines not always suited to the convenience of the mothers, but to which they had to adapt. The women therefore lacked the control over the ordering of their own lives which they could exercise in their own homes, or at least the familiarity of an environment to which they were accustomed, and so, despite their lack of confidence, overwhelmingly the women were relieved to leave the hospital.

I wanted to get home. I was slightly apprehensive at not having the midwives around in times of trouble to say, 'What about this?' But in fact I settled down to a much better routine. There's that sort of panic in hospital that if they feed at twelve o'clock and you haven't eaten your lunch by twenty past twelve, it gets taken away and you lose it altogether; and if you have to feed them at five o'clock in the morning, by the time you settle them it's six

o'clock, and then it's tea at quarter-past six and you're up for the day...if you're having a rest then you can be sure enough the doctors'll come round or-. You can pace yourself much better at home...

(Audrey:10:2:24)

None of the women thought the hospital food was good, and many condemned it scathingly. Other complaints from various women included: lack of clean laundry especially baby-gowns and cot sheets; disturbance from other patients or their babies; the inconvenience of shared bathroom facilities; lack of cleanliness of the bathroom facilities; lack of privacy; lack of peace and quiet generally; too high a room temperature; uncomfortable beds; restrictive rules; being in an unfamiliar environment; and separation from husbands and other close supporters. Also, it was common for women to feel overwhelmed and divorced from reality in hospital.

I think you lose your privacy a bit in hospital, cos visiting time there is a long time, and you've got people coming in and out. And at first when it's all new you don't want anybody to see you just in case you're doing it wrong or something. You haven't got the confidence.

(Pauline:34:2|:6)

I mean your baby might be really quiet, and then somebody else's baby starts crying, you know, and I mean I just felt that I was just getting enclosed in, you know. You've got this little space that you've got which is yours really, and then you've got all these people coming in, and



I think probably being in there over Christmas as well...

(Barbie:30:2:31)

But when you're in that situation you can't think of anything else because it's all very kind of medical orientated, and, I mean, you're shut in a little room in the hospital and you haven't been out for ten days and it gets a bit obsessive after a while.

(Sarah:2:2:16)

Well, I thought I'd ruined everything, you see. 'Now I won't be able to breastfeed now.' You know. 'He won't want me after he's had the bottle' sort of thing. You know, I was worried about that. I think you're in a different world in that hospital anyway, and things get all out of proportion anyway. Really I should have come home and battled with it there I think.

(Marcia:35:2:7)

On the positive side, most women praised at least some aspect of their hospital stay, and some were very complimentary.

### 9.1.3 Professional Help and Advice

Through their ignorance of babies the women felt dependent on the staff for help and advice, but for various reasons they frequently felt that the help was inadequate or not forthcoming.

Hospitals are bureaucratically-run organisations, designed around impersonal relations between patients and staff. The mothers were being cared for in unfamiliar

surroundings by strangers. Patients and staff knew nothing of each other as individuals beyond the boundaries of the hospital ward, and their relationship remained limited to that between patient and provider of health care. The pattern of changing shifts meant a lack of continuity in the staff, and further reduced the chances for becoming acquainted during the hospital stay. This lack of mutual understanding of each other as individuals could lead to difficulties despite the mothers' desire for knowledge and the staff's desire to impart it.

For instance, for the women there was a tension between wanting or needing help, and wanting to be independent and learn in one's own time and way, but each woman had her own individual needs, desires and perceptions. The staff therefore had to try and strike a balance between being helpful and not interfering, and the staff, too, were making their own interpretations. The women's reports indicate the variety of interpretations and responses on both sides.

...they came and literally dumped him beside me, and that was it...I didn't really know what to do with breastfeeding, and it's the kind of thing I think you need to be shown. And whether it was because it was a weekend or not I don't know, but there wasn't an awful lot of staff on, and it was kind of-, it seemed to be, 'Well, you're a woman, you should know what to do.'

(Cynthia:14:2:2,4)

They didn't interfere but they would always help you if you asked them to... they didn't sort of come over and

interfere with you.

(Hilary:1:2:2,4)

...some of them were quite happy to leave you alone to get on with it. Others would just keep making a nuisance of themselves.

(Nancy:9:2:10)

On the whole the working-class women seemed to want more to be shown without having to ask, and seemed to expect to be given more explicit instructions, than middle-class women. The mothers were generally reluctant to ask for help or instruction, but complaints of having requests for help ignored or refused came mostly from working class women.

...with sort of like washing (the baby) and things like that first of all we didn't have much help cos there weren't many people. There was this older ward clerk, auxiliary nurse, whatever she is, and I said something about, 'Can you show me top-and-tailing him?' She said, 'Haven't you seen him?' I said, 'Well, I did look over the shoulder while someone was doing someone else's.' And she didn't have time. She said I had to watch someone else again or something.

(brackets added)

(Isobel:31:2:7)

On the other hand, a number of middle-class women described how, on finding the staff's help unhelpful, they made a conscious decision to give up their dependence

on the staff, and to use their own initiative and judgement to sort out their problems.

Well, I'd try her to start with, and when it was obvious I was getting nowhere I'd ring for them and they'd come, and it was a bit frustrating really because the nurses'd be frustrated that she wasn't taking, they'd literally try and sort of jam her on, and by that time she'd woken up properly, she'd be howling away and screaming and going red in the face, and they'd be trying to force her on to the breast, and I sort of felt awful cos I couldn't tell them to go away really having just rung for them, and after about the first two or three days I gave up actually ringing and asking for help because I felt that I'd probably be able to do it better myself, even if it meant sort of trying for an hour.

(Tabitha:4:2:9)

However, when faced with an apparently urgent problem all women wanted an instant solution, or at least a clear course of action. Also, all classes of women could suffer from not having sufficient knowledge even to know what questions to ask, and from feeling reluctant to pester strangers with what might seem stupid questions.

Well, I made a lot of mistakes along the way, but some of it might have been my fault for not asking. I didn't pester enough. I didn't like to. I'm like that. I don't like to be a burden on anybody...

(Marcia:35:2:11)

For this reason, one woman, whose own mother was on the ward nursing staff, waited for an opportunity to ask her for help.

When she came to visit me, I said, 'Mum, will you help me?' Because, I mean-, I don't know-, I just felt I could ask her easier. She didn't mind, and she got me latched on.

(Pauline:34:2:14-15)

The women frequently reported feeling intimidated by the staff.

...a couple of Sisters...they were nice, but they were fairly sort of authoritarian and bossy, and you all sort of think it's the first time you've done anything, you feel that they might be looking at you, it makes you even worse. Quite off-putting that was.

(Hilary:1:2:16)

...I got a real telling off from her which didn't help matters...she said, '...don't you know you should feed her more often? You should have fed her, why's she going so long without feeding?' And although I felt OK, I was in no state to argue with her about it, and yet afterwards I thought how unreasonable it was to say that, because as I said, what you don't know you can't ask.

(Irene:3:2:6-7)

Other explanations offered by the women for their lack of satisfaction with the help received in hospital included short-staffing and the attitude of nurses.

...they were very short-staffed anyway...they were very rushed off their feet. That's probably why it was difficult to ask their advice, because they were so busy. It made it seem a bit awkward.

(Sheena:6:2:12)

...everybody was complaining in the hospital about the attitude...Not what people expected on a maternity unit...a lot of us had got this idea that it was a very happy, jolly place and they came round and um, what's the word? - it wasn't just a job. Whereas a lot of the nurses there, whether we got a bad lot we don't know, but it seemed very much that they were there on their shift from what, seven till whatever it was, and they had x, y and z to do, and if you asked them anything, if they could help you, they'd say, 'Oh well, I'll have to see if I get time,' and all that...I mean it wasn't excessively busy. But as I say, some of them couldn't have been nicer, but others could have. We couldn't understand why they were on a maternity unit cos they didn't really seem interested in babies and mothers.

(Cynthia:14:2:12-13)

A desire for more personal, individual care was evidenced by the recurrence in some of the working-class and lower middle-class women's accounts of the idea of nurses 'sitting' with them. Sitting down at the patient's bedside means that the nurse is

responding to the individual and discovering her particular needs and fears rather than applying set rules or giving standard advice.

I would have liked somebody to sit with me and watch what I did while I was breastfeeding. But as the hospital was so busy, they was short of staff, I just got on with it myself and just hoped for the best, but I would have liked somebody to sit with me and just watch to make sure what I was doing was right...one day she was unsettled and I was getting a bit uptight, a bit upset, I did call a midwife to come and have a look to make sure I put her to the breast all right, and she started to suck, and the midwife said, 'Yes, that is fine, you are doing well, that is fine,' and she went off. You know, she never said to me, 'Right, I'll stay with you until she's finished feeding.' I know it would have taken her about half an hour until I would have winded<sup>4</sup> her up and everything, but they weren't-, just weren't prepared to sit with you, which I thought was very unfair.

(Michelina:22:1:7)

And they didn't really just sit down and explain why, you know, or say anything why they thought he was bringing it all back up or anything. There was one nurse there, she was very nice. She came over in the end and sat with me

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<sup>4</sup> i.e. brought the baby's wind up.

and talked to me for a little while.

(Trudie:45:2:6)

So by the Monday I said, 'Right, that's it, I'm going to bottle-feed him, and I did bottle-feed him for two days, but...the Monday night I had this blood transfusion, and the Tuesday I woke up feeling a completely different person. By then I was more my normal self, and I thought, 'What are you doing on the bottle?' So I said, 'Can I have another go at breastfeeding?' 'No. If you've changed you've got to stick to bottle. You can't change back again.' So, of course, all day Tuesday I was quite tearful, because breastfeeding is what I had wanted to do. And luckily enough Wednesday a different nurse came round and happened to say, why wasn't I breastfeeding? At which I immediately burst into tears. And she sat down and we talked about it, and she said, 'Well, if that's what you really want to do, we'll have a go.' So we started on the Wednesday and he took to it fine, and we've been going great guns ever since.

(Cynthia:14:2:4-5)

Middle-class women referred less explicitly to needing this sort of prolonged personal attention *for gaining reassurance or for sorting out their problems, perhaps* because they had more self-confidence or because they felt more that they ought to be able to manage independently.



With breastfeeding, the staff were having to balance giving help and encouragement without pressurising or inducing feelings of guilt or failure. Most of the women were keen to breastfeed, but they all felt strongly that no one should be subjected to pressure, and, of course, individual interpretations and reactions vary.

They were very good, yes, and they sat down and talked to you and things like that. The only thing was that they said persist, and I just felt that he was getting traumatised, and the more that I'd persist and try and to put him-, because there was one side that he just did not want, and they said I persist on that side for a while, and he'd get really angry about it, and then I'd get upset, saying, 'No, let him have a rest for a while,' and they said, 'Oh no, persist.'

(Tammy:19:2:4)

...they're very keen to help and there was an awful lot of pressure to breastfeed as well, an awful lot of pressure to breastfeed...At the time I thought they were too pressurising, but now I think I'm glad they were like that because otherwise I think I might have ended up giving up really...If they hadn't insisted I probably would have opted for the bottle a couple of times...

(Tabitha:4:2:9-10)

One came up and congratulated me. She'd come on duty, and she said, 'I hear you've made a decision.' And I

didn't know what she was talking about. It was to bottle-feed. Cos she was saying how difficult it is with Caesarean, and she (the baby) was proving difficult. But they never say to you, 'You should go on to bottle.' If you want to breastfeed they let you. They try to help you over your problems. But she said, 'I'm so glad.'

(breastfed two days) (brackets added)

(Priscilla:18:2:6-7)

Feelings of being pressured to persist with breastfeeding were reported by a few working- and lower middle-class mothers. On the other hand it was common for middle-class women to feel that they had not been given enough encouragement to breastfeed. But the need for the staff to strike a balance between giving help and encouragement as against interference or pressure probably explains why some of the middle-class women reported feeling lost for the first few days before help became forthcoming. This is how Samantha made sense of her experience. (She had had a Caesarean which meant she spent the first two days after the birth in a single room drugged with pain-killers and under close supervision before being moved to the main ward.)

...if anything they just left you to get on with it...

(Interviewer: Did you find that was what suited you?)

...Days one and two almost don't count, cos on the third day I came out to the big ward anyway, so sort of days three and four, when in fact I perhaps could have done with a bit of guidance on what to do. I didn't really know

what to do, but I suppose they were sort of letting you find your own way. But, having said that, on about the fifth day when I really wasn't quite sure where I was going breastfeeding - I mean we were managing but it wasn't perfect by any means - they obviously must have been watching, sort of just making sure what was going on, cos they sort of said to me, 'Well, do you want to carry on breastfeeding or do you want to go on to a bottle?' And I felt quite strongly that I wanted to carry on breastfeeding. Then they started whichever shift was on, they made it their sort of responsibility that they would help me with the feeds, and try and get him to latch on to me and just make sure everything was going all right...So I think it was that they really couldn't come out and say, 'Well, we think breastfeeding's best, or bottle-feeding.' It had to come from me. But having said that I was keen on breastfeeding, they were keen to help me. Those days three and four I felt a bit lost.

(Samantha:27:2:8-9)

#### 9.1.4 Division of Labour and Fragmentation of Knowledge

The midwife is the only specialist in maternity trained to care for the mother and baby together as a duo on a continuing basis right through pregnancy, the delivery, and the neo-natal period. She is also qualified as a practitioner in her own right. However, the organisation of modern maternity care prevents both continuity of care and the

independence of midwives. Women see a succession of different midwives throughout their maternity care, and on the post-natal ward she and her baby will also be attended by more junior and student nurses, auxiliaries and nursery nurses. Also, midwives cover only routine care and are subject to the higher authority of doctors to whom any complications have to be referred. It is at this level that a fundamental fragmentation occurs in modern western medicine: until birth both mother and child are under the management of the obstetrician. After the birth, medical care of mother and child is split between the obstetrician and the paediatrician.

So, after the birth, care of mother and baby is split between three specialisms, with the overseeing of breastfeeding left to the midwifery staff who have (or are supposed to have) the necessary knowledge of everyday practicalities to impart to mothers, and who are qualified to do the practical work of looking after the health of mother and baby. But the midwifery staff are working within the parameters approved by doctors, to whom 'medical' problems have to be referred for decision. The negative effects of this division of labour and fragmentation of knowledge can be seen in the experiences of two women in this study during their hospital stay.

In the case of Sarah, the junior medical staff were following rules of procedure, and she did not have access for several days to the person senior and confident enough to make the authoritative judgements and statements that she found helpful. Her problem was that her baby was not gaining weight adequately according to the hospital's criteria. She was told to feed more often and to top up with formula, but there was no apparent improvement after three days. Her advice seems to have been conflicting, but she got the overall impression that the staff had no faith in her breastfeeding capabilities and that they thought she should change completely to bottle-feeding. Consequently she

gave up breastfeeding, and after being fed completely on formula for a whole day the baby was judged to have put on enough weight to be allowed home.

...the day I was coming out, they already checked me over and said I was fit to go home, and there was a young lady paediatrician who'd been looking at Elena most of the time, but she said, 'Before you go out I just want my Registrar to have a look at her.' And he came that morning, and he checked her over, and in fact he said, 'Well, you can see there's nothing wrong with this baby, she's perfectly all right, she's alert and healthy,' um really with the idea that, you know, 'You needn't worry too much about the fact that she's lost this weight, and the only thing is that she is a bit small anyway,' so he said, 'That's why we're a bit more worried about her.'...And he said, 'What are you doing about feeding?' So I said that I'd had all this trouble with the breastfeeding and I'd decided to go on to bottle-feeding, and he was so nice. He said, 'Well, you don't have to give it up just because it doesn't seem to be working now. When you get out of hospital you might find that if you start breastfeeding again it all comes together, and you can always breastfeed and top up if you want to. You don't have to do one or the other, you can do both if you want to.' And nobody else had said that to me...Their attitude was either you

breastfeed or you bottle-feed but not that you do both. I mean they were suggesting I topped up in the hospital really to get her weight up, but not as a sort of permanent measure. But he was so sort of sensible about it and reassuring, and he obviously realised I was very upset about it, and I think he was really the only sort of sensible person who spoke to me about it in a way. He seemed to be more, I don't know, more um, what's the word I want? Well, less rigid in his ideas perhaps.

(Sarah:2:2:17-18)

(Sarah resumed breastfeeding with formula supplements, and after her return home an alternative explanation for her baby's poor weight gain arrived when she received a test result which showed her baby had a urinary tract infection, for which antibiotics were prescribed.)

Pamela's case illustrates how knowledge of breastfeeding falls between different stools. Several women in the study were on medication for conditions unrelated to their pregnancies (i.e. epilepsy, kidney complaint and cancer). Whilst advice was forthcoming during their pregnancies as to the effects of their medication on the baby, in no case did a doctor seem to think of looking into the effects on breastfeeding. Two mothers did enquire during their pregnancies, Diane of her own initiative and Stella after a midwife had pointed out the possibility of problems. But in Pamela's case:

Well, I've been taking it for twelve years, and as soon as I was pregnant obviously I checked to make sure it was safe. And everyone checked, the doctors and my

consultant. They said, 'No, no problem with pregnancy at all.' So I carried on. I never thought about breastfeeding, and I don't think anyone else did either because no one ever mentioned anything about breastfeeding... By the second day, second full day...he wasn't crying. He was quite inert and didn't cry, and they were all teasing me, saying, 'You wait, he'll cry.' But this obviously set off alarm bells. The nurses who reported it back, they must have done, and suddenly a doctor came through...and said, 'I'm sorry, but we don't think you should breastfeed because of t- (name of drug).' They don't know what the side-effects are, but there may be some side-effects...(The nurses) were very sympathetic, and they said that it taught them something because they didn't know that either. So it's still, it's a bit of controversy actually because the doctor who told me was the Consultant Registrar concerned with me, but when I saw the paediatrician about something else with him and told him what had happened, he said, 'Oh, I would have told you about it but would have advised you that there was no problem.'...And he even said to me, 'It's not too late now.' This was about three or four days later. 'It's not too late now while you're still in hospital if you want to start breastfeeding

again, and we'll help you.'

(brackets added)

(Pamela:16:2:4,8)

But Pamela was not convinced that the drug was safe for her baby, and decided to stay with formula 'knowing it was safe.' (p.8)

#### 9.1.5 Conflicting Advice

A major problem for the new mothers was the amount of contradictory messages they received from staff during their hospital stay. This seemed to apply to every aspect of their care, not just breastfeeding.

The lack of continuity of care in itself would not be conducive to the women receiving consistent help and advice.

...they were all very helpful. But they all had different ways, so that was very unhelpful...one would sort of try and sort of put the baby on to you, and another, another way, and one would say you were holding her too tightly, not tightly enough, or you weren't encouraging her enough, and you weren't sort of pushing in the right places.

(Priscilla:18:2:3)

I found the difficulty was that one nurse would be ever so helpful, and come over and really sit with me and help with positioning and help sort of - because she would throw her head around as well - and had somebody hold her. And then that nurse would go off duty, and there'd



be another nurse who wasn't quite so happy to sit and wasn't so willing to help. And there wasn't a lot of continuity. Some nurses said, 'Sit her up on your arm,' and some said, you know. All the positions were different. And in fact in the delivery room the nurse that showed me, showed me to hold her under my arm that way. You know, the legs underneath. And then-, cos that's the way I continued to feed the first time (on the ward), and the nurse came up and said, 'What have you got her like that for?'

(brackets added)

(Andrea:17:2:8)

Middle-class women tended more to treat conflicting advice as a repertoire of different ideas from which they could choose what suited them rather than believing there had to be one right way, although when anxious about an apparent problem all the women wanted clear answers.

But much of the conflict in breastfeeding advice can be traced to the juxtaposition of ideas from the medical model and the natural ideal. Some of the women talked of the conflicting advice in terms of a generation gap, younger staff tending to have more confidence in the natural ideal, and older staff clinging more to the medical model.

I found the older midwives had certain ideas and the younger midwives had certain ideas, and I got such conflicting advice. And one night when I was really in pain I just ended up going to bed in tears, and they kept

coming in, 'Oh, what's wrong, what's wrong?', cos one had told me one thing, one had told me another, and I just told them to push off and leave me alone in the end.

(Interviewer: And what were these different things you were being told?)

Well, it was like whether to go on the breast pump or to express or not, because it increases, you know, sort of supply and demand sort of thing. One of the older midwives said to go on the pump, but I mean it didn't work anyway particularly so it was sort of neither here nor there in the end. Then one of the student midwives said she didn't think it was a good idea. She went and asked another Sister and I think they argued about it for about ten minutes. About whether it was a good idea or not. And I was using a nipple shield, because we were having such battles with him every feeding time, and it was just awful, cos I mean they were sort of trying to ram him on and I was getting sore and everything, so one of the older Sisters said, 'Why don't you try him on the nipple shield?' And he was really happy with that, so I was happy and it relieved me, and then somebody came on at night and said, 'Oh, you mustn't use that again, we don't like that.'

(Nancy:9:2:8-9)

## 9.2 BREASTFEEDING DIFFICULTIES

An examination of how actual feeding problems (see Table 9.3) were dealt with reveals how ideas from the natural ideal had been adopted by the hospital, but that understanding of and faith in this approach seemed to be limited in both mothers and staff, often causing considerable anxiety to mothers.

### 9.2.1 Feeding in the Delivery Room - Preliminary Attempts

Although many women were given their first opportunity to breastfeed very shortly after giving birth whilst still in the delivery room, on the whole they did not seem to find this a very useful experience. Either they themselves felt too overwhelmed or exhausted by the events of the birth (often involving medical intervention and drugs) to be able to take in this new experience, or the babies did not latch on. Within the parameters of the natural ideal, feeding at birth is recommended as an aid to the establishment of breastfeeding because the baby's sucking reflex is normally strongest at birth (Stanway & Stanway, rev. 1983, p.81), but the staff did not appear to treat this as a serious feed: as a rule it seems to have been limited to a minute or two, and help was seldom offered if the baby did not latch on. Perhaps the staff had to tread a tight-rope between facilitating an early breastfeed and not imposing yet more unfamiliar demands on a mother physically and emotionally drained from giving birth. More importance seemed to be placed on giving the new mother and father a private time together with their new baby.

They put him on the breast in the delivery room for a sort of couple of minutes. I can't remember how long it was, just to suckle...It didn't really do an awful lot for me. I was fairly whacked anyway, and putting him on in the

delivery room, it just seemed a bit-. To me it seemed a bit too much to cope with, to be honest.

(Gwen:44:2;1)

They put the baby right on you immediately after the delivery, and put her to the breast. She didn't adhere straight away. She just kind of looked around and cuddled with me a bit. We thought it was nice, to leave the two of us - well, actually the three of us - by ourselves for a half-hour or so. A nice experience.

(Roberta:46:2:2)

However, as feeding attempts progressed in earnest over the post-natal hospital stay, mothers encountered a variety of problems which invoked considerable anxiety.

#### 9.2.2 Babies not Latching On or Feeding

The most common problem seemed to be that babies did not latch on properly or seemed reluctant to feed from the breast. Over half of those attempting to breastfeed (25) reported this sort of problem, whereas there were only three reports of babies having difficulty sucking from a bottle (and virtually all the mothers mentioned that their babies were given milk or water by bottle at some point during the hospital stay). Sometimes the explanation for the difficulty lay in the physical condition of the baby. In five cases it was attributed to too much mucus in the baby's stomach and was solved either when the baby vomited spontaneously or when the stomach was pumped. Some babies, especially if jaundiced, were too sleepy to feed as often or for as long as was thought necessary either by the mother or the staff. Difficulties could also lie with the shape of the mother's nipples. Inverted or flat nipples gave little for the baby to latch

on to, although the baby's sucking could make them more prominent in time. Some women found that engorgement after the milk had 'come in' also had the effect of flattening the nipples. Many women found nipple shields useful for giving the baby something to latch on to while the condition lasted. But in many cases mothers simply found it difficult positioning the baby at the breast and getting it to feed. Mothers often interpreted their baby's refusal to feed as a rejection of the offered breast.

He wouldn't fix on at all, and he just turned his nose up...He'd open his mouth, and he wasn't opening his mouth wide enough to really get on to the nipple properly so every feeding time was a real struggle with a midwife sort of ramming his head on to me to try and get him to stay there, and he just didn't want to...they gave him some expressed milk and he had some soya milk as well...you gave him a bottle which was flowing sort of freely and easily, and he was as happy as a sandboy.

(Nancy:9:2:3,4,5)

Some women said their babies were 'lazy' and 'not prepared to work at it', and their babies' apparent preference for bottle-feeding was explained in terms of the milk flowing more easily through a teat, and by doubts about whether there was really anything satisfying in the breast before the milk 'came in'.

The natural ideal approach has led in recent years to particular interest in how babies are positioned at the breast, with the result that an incorrect latch is seen as the cause of many breastfeeding problems, e.g. 'nipple pain and soreness without overt signs of infection; protracted feeds; a baby that cries hungrily after a feed and "*breast milk*

*insufficiency*." (RCM, 1988, p.17, italics in original). In this study it was common for mothers to describe how they struggled on their own to position the baby. Sometimes this was through choice, sometimes through being too shy to ask for help, and sometimes the women thought that help was not forthcoming and they were just being left on their own. However, the mothers all seemed to have at least some help at some time, and many described how nurses spent quite long periods (up to half-an-hour) helping them to get the baby on the breast. The variation in help from different nurses has already been shown above. Whether or not the women thought this help had been useful or not, what comes across in their descriptions is that it was usually an unpleasant experience. Being helped to position the baby at the breast meant having one's body manipulated by strangers in sensitive places while feeling physically gauche, but what is striking in the women's accounts is how often they seem to have experienced this help as violent.

Helpful, but embarrassing. Having all these women putting their hands all over me. It wasn't very nice, but you get used to it.

(Donna:47:2:5)

Well, the first time I had this black nurse, and she just sort of shoved him at me and twisted me round and things, and didn't have much luck. Put me off a bit...But then later on in the evening...it was an older woman this time...she just sort of came up to me and she said, 'Right, here you are.' She sort of grabbed hold of him and pushed him there, and she said don't squeeze him so much, and she

just sort of put him there and he took straight away, and it was fine after that. She didn't sort of start twisting my body round and pulling my arms here and there like the other one had done.

(Isobel:31:2:2)

Some of them were very gentle with her, and others were very rough, and I found the ones that were very rough with her, you know, I found that very distressing. You know, they'd get hold of her head and just sort of *hold* it on the nipple...

(Interviewer: Did it upset her?)

Yes, she screamed. She screamed, and that made it worse for me.

(emphasis in original speech)

(Andrea:17:2:9)

The Sister used to really get hold of me and pinch me. This was at the colostrum stage, and she'd try and pinch me to get a bit of something coming through, and so she had me between fore-finger and thumb, and she had Melissa by the scruff of her neck and she would shove her on, and she was screaming a real piercing scream. It wasn't a 'wa, wa, wa, I'm hungry' cry, but it was a 'ahhh, you're hurting me' cry, and I felt like crying too because, well, partly because she was hurting me like mad, and I

was upset that she was hurting-, yeh, I thought she was hurting her, and I think it was a tearful stage anyway. You know, sort of third day, stitches are aching, bosoms are aching, baby's crying and not locking on properly, and then some great gruff nurse comes along and squeezes you up, you know.

(Connie:23:2:22)

When babies did not appear to be feeding sufficiently, the mothers became anxious that they were not receiving sufficient nourishment. It was common, too, for the staff to say that supplements by bottle were necessary in this situation. Even mothers who feared that giving supplements would jeopardise their own breastfeeding believed in the necessity of their babies receiving the extra nourishment by bottle.

Seeing their babies feed with relative ease from the offered bottle further undermined the women's confidence in their own abilities, and it took active determination to continue their own efforts.

### 9.2.3 Sore Nipples

Many women suffered badly with sore, cracked or bleeding nipples, despite the creams available on the ward. In the medical model approach sore nipples were thought inevitable with the commencement of breastfeeding, especially for fair skinned women, and to minimise the problem the time spent on the breast should be restricted in the first few days, gradually building up to ten minutes on each side. The natural ideal thinking on the cause of this problem is that a little soreness may occur in the first few days but it should soon clear, and skin type has no significance if babies are sucking correctly. If babies are fed often for as long as they want they will not suck so hard because they



will not be ravenous. Any prolonged or troublesome soreness is most likely the result of faulty latching which can be difficult to detect since professionals are used to bottle-feeding and may not recognise the different embouchure required for sucking from a breast. (Palmer, 1988, p.27; RCM, 1988, p.17; Stanway & Stanway, rev. 1983, p.157)

Faulty latching on does not often appear to have been offered to the women as an explanation for their nipples becoming badly sore, and many of the staff seemed still to subscribe to the view that gradually increasing the length of feeds prevents soreness. The women were therefore subject to conflicting advice. At first they suckled without restriction as directed, but if soreness occurred the only explanation offered was that they had fed too long.

...everyone had a different story as to how you should carry on, and he ended up making me sore because he was sucking too long, and I had to go on the breast pump in the end, until the milk came in. But it was all a bit traumatic. I was very close to tears a couple of times, because some people had said, 'Oh, you should never have let him do this,' sort of thing. 'You should have had two minutes each side the first day.'...Of course, it was too late by then, nurses had said, 'Oh, the more you let him suck the more your milk will come,' which I suppose is true providing you don't let him chew away at nothing because there was nothing there.

(Marcia:35:2:4-5)

(The fact that several women, when blaming unrestricted feeding for their sore nipples,

used the word 'chew' when referring to the baby's sucking lends support to the idea that the latch was not as recommended.)

The solutions offered by the staff seldom seemed to involve attention to the baby's latch, and if anything carried the risk of accustoming the baby to inappropriate sucking technique, since (apart from creams) they involved either the use of nipple shields or bottle-feeding, or both. In practice, though, the use of nipple shields did not seem to affect breastfeeding adversely in the long-term. Rather, the women using shields for this purpose talked of them as a godsend - a temporary measure which enabled them to carry on breastfeeding, but which they were able to discard in time. But often the soreness was so severe that mothers were advised to rest their nipples by stopping or limiting breastfeeding, and expressing their milk, with an electric pump, to be given by bottle. When the amount expressed was not sufficient to satisfy their babies, formula was also used. The women were not aware that expressing was unlikely to yield as much milk as the baby would get by sucking. Having to rest the nipples caused anxiety that their milk production would be adversely affected by lack of nipple stimulation, and their apparent lack of yield on the pump also undermined their confidence in their abilities.

#### 9.2.4 Milk Insufficiency

Although there were no set feeding times at fixed intervals during the day, in practice mothers were led to expect a more or less four-hourly feeding pattern. In general they were told by staff to feed 'on demand', but not to feed sooner than three hours or later than five hours (with a few variations). When babies seemed unsettled and fretful before the three hours were up, mothers became anxious. Occasionally there was an explanation which did not blame the mother, e.g. fretfulness in babies during the

first day after a forceps delivery being attributed by staff to the baby's having a 'headache'. But in general mothers were quick to blame their milk. Babies who demanded more often than three-hourly were seen as unsatisfied. When supplements of formula seemed to satisfy the babies for longer (and seemed to be taken by the babies more readily than a breastfeed), mothers' doubts about the adequacy of their own milk seemed confirmed.

...I could see with a bottle that she was getting so many ounces and she was drinking it and she was happy and going down. And she was sleeping sort of four to six hours, but when she was with me, breastfeeding...she'd wake up within an hour and she'd want more...

(Tracey:26:2:8)

According to the natural ideal, newborn babies can be expected to demand very often indeed, and the way to increase an apparently insufficient supply is to feed more often. According to the medical model a feed should satisfy a baby for about four hours, and feeding before three hours has elapsed will result in the baby being upset, either by wind through having sucked on an 'empty' breast, or through not having had sufficient time to digest the last feed and therefore being over-fed. In the study there were plenty of instances of mothers being advised to feed their fretful babies 'more often' and even to be flexible about the three hour rule, and most mothers seemed to understand that feeding more often would stimulate their milk production. However, mothers still seemed to harbour the idea that if a baby demanded sooner than three hours there was something to worry about, and there were also instances of nurses suggesting to mothers that feeding more often than three hours was wrong, and suggesting

supplements.

...in the mornings he was going about three hours between feeds, and in the afternoon he was on nearly hourly, but I wasn't getting particularly sore so that was all right...It was a night nursing auxiliary, and because she had to write on this little chart how often you fed, in the afternoons it would be two, three, four, five, like this, and she came along and she looked at the chart, she said, 'Tut, this is terrible,' she said, 'We can't have this. He's on far too often.' And she told me that my milk supply had diminished in the afternoon and that's why he was going on so frequently, and she actually in the night gave him boiled water when I'd fed him at midnight...So I wasn't too happy about that, but then.

(Maureen:11:2:9-10)

Although breastfeeding is now recommended as sufficient to provide all food and drink for babies right from birth (DHSS, rev. 1983, p.9; DHSS, 1988, p.7), many women seemed to feel that their babies were particularly vulnerable in the first few days to under-nourishment until their milk 'came in', a view which seemed to be echoed by the hospital staff with, for instance, their testing of blood sugar levels after birth (see section 9.2.6). Colostrum was valued for conferring immunity factors, but was not regarded as real nourishment, and some women talked of their breasts not having anything in them before their milk 'came in'.

...he ended up making me sore because he was sucking too

long...nurses had said, 'Oh, the more you let him suck the more your milk will come in,' which I suppose is true providing you don't let him chew away at nothing because there was nothing there. But when the milk came in it was a lot better, although he was very, very hungry.

(Interviewer: How do you mean it was better?)

Um, emotionally-wise. I felt a lot better that there was actually something there.

(Marcia:35:2:4-5)

In the following example the mother faced the dilemma of wanting to calm a fretful baby and to stimulate her milk supply whilst believing that feeding more often than every three hours would result in over-feeding. She resolved the conflict by justifying her action in terms of her belief that colostrum was not real milk.

While I was in hospital I sort of-, every time he cried-, not screamed, not every time he grizzled, but every couple of hours or whenever, I fed him. Cos I know you're not feeding them first of all cos there isn't any milk there for the first couple of days, but you have to do it to get the milk coming in, so. He was fine...In the hospital they say, I think it's not sooner than three hours and not longer than five hours or something, but I must admit I didn't take a lot of notice. I think once or twice I fed him again after a couple of hours, cos I mean they're not getting any

milk, it doesn't matter for the first couple of days.

(Isobel:31:2:3)

#### 9.2.5 Over-feeding

In the following example conflicting advice includes a baby's fretfulness being explained in terms of over-feeding.

...And then I was told I'd fed her too much. You remember I told you I'd fed her twenty minutes each side?

(Interviewer: You'd done what you'd been told to do?)

Yeh. Yeh. What you have to remember is, as the shifts change different staff have different opinions, and conflicting advice was incredible up there. I mean every staff-change gave you different advice. I was told I'd fed her too much, and I should only feed her on five minutes...they said, 'Mrs. Coombe, your little girl's been crying all night long. You've given her-, *you've* given her colic. Sister says you're only to feed her five minutes each side.' So then there was a staff change, you see, and I fed her five minutes each side, and she cried and cried and cried and cried, and I said to the midwife, 'What can I do?' And she said, 'She's still hungry, feed her some more.' And I said, 'But I've been told only feed her five minutes.' And the new Sister, day Sister, said, 'You can't

over-feed a breastfed baby. Feed her.' So I fed her.

(emphasis in original speech)

(Connie:23:2:10)

#### 9.2.6 Medical Criteria for Well-being

The mothers' lack of confidence in the adequacy of their breastfeeding efforts was not diminished by the hospital's use of certain measurable criteria for monitoring the baby's well-being, e.g. the babies were weighed periodically, blood sugar measured, and mothers required to keep a record of times and duration of feeds and 'wet and dirty' nappies. The staff often advised the giving of formula citing the baby's failing (or danger of failing) one of these measurements.

I tried very unsuccessfully to feed him throughout the rest of the day whenever he seemed to be rooting, but they gave him a bottle of milk in the end...They said he had to have it because he wasn't taking my milk and his blood sugar was very low. Because he was a big baby he was more prone to this apparently.

(Maureen:11:2:5)

Even women who were reluctant to use bottles for fear of hindering the establishment of breastfeeding did not feel able to argue against the authority of 'scientific' evidence.

#### 9.2.7 Use of Nipple Shields

As has been indicated above, several women found nipple shields useful for dealing with the problems of flat nipples and sore nipples (see Table 9.4).

In fact, mothers regarded them as a life-line to continuing breastfeeding. However, their use is somewhat controversial because of the risk that the baby will learn

**TABLE 9.4: REASONS GIVEN BY BREASTFEEDING MOTHERS FOR USE OF NIPPLE SHIELD IN HOSPITAL**

	<u>No. of women</u>
latching on	7
sore nipples	6
both	1
Total using nipple shield	14
Total no. of breastfeeding mothers	42

an inappropriate latch for breastfeeding. Many mothers were very distressed suddenly to find staff expressing disapproval, without any other practical suggestions or clear courses of action being offered.

...one night, I think it was just after my milk had come in, I was quite full and she just wouldn't take the nipple at all, so a nurse recommended I use a nipple shield just so that she had something more prominent to latch on to, and she really seemed to take to that, so what I used to do after that was I used to try her without the nipple shield for about five minutes or ten minutes, and if she didn't take then I'd put the nipple shield on, and she'd almost always used to take with the nipple shield on. But then a nurse came and saw me using the nipple shield, cos I had to have a blood transfusion on the fourth day I think it was, so I had to ask the nurse to come and take her out the cot to give her to me cos I was confined to bed, and when the



nurse realised I was using this nipple shield she got quite annoyed and said that I'd ruined her and she'd never take to the breast now...

(Tabitha:4:2:14)

In practice most of the mothers who used nipple shields continued breastfeeding successfully and were able to discard them in time. But the example illustrates how the rules of the natural ideal can be applied in as rigid a way as the rules of the medical model, without addressing the particular circumstances faced by the mother at the time.

### 9.3 FULFILMENT OF EXPECTATIONS

At the first interview the women had expressed their beliefs as to the advantages of breastfeeding, and their fears and doubts about its practice. Did their experiences of breastfeeding in hospital confirm or deny these anticipations?

#### 9.3.1 Breastfeeding as a Norm

Before birth the women in general regarded breastfeeding as the best way to feed a baby, and many had always assumed they would use this method. However, bottle-feeding was also regarded as a normal feeding method, and a reliable substitute. In the hospital the normality and preferability of breastfeeding were basic assumptions. However, to reassure mothers who did not want to breastfeed, or who decided to give it up, bottle-feeding had also to be treated as normal, and a good substitute method. But more than this, hospital practice treated bottle-feeding as a necessity, even for breastfeeding women. Despite government recommendations that breastfeeding should be sufficient to meet all the new-born baby's needs for food and drink, and that the giving of any other fluids should be avoided (DHSS, rev. 1983, p.9; DHSS, 1988, p.14), all but one of the women in the study reported that their babies received at least

something by bottle during their hospital stay. This was not because mothers had free access to bottles of formula or water, or frequently demanded them. As bottles had to be brought to mothers by members of the nursing staff, they could only be given with their approval. In fact, it was usually the staff who suggested their use, and in many cases they fed the bottles to the babies themselves.

Use of formula supplements, or expressed breast milk by bottle, as part of the solution to problems, has already been referred to. Drinks of water or glucose were also often given to cure fretfulness or as extra fluid. But bottle-feeding was used as a matter of policy even in the absence of problems in that it was hospital routine that mothers should be given sleeping pills and sleep undisturbed through the first night after giving birth, and their babies were fed by bottle by the staff. At the beginning of the study this was usually donated expressed breast milk for babies of mothers who intended to breastfeed, but later in the study this supply seemed to stop and mothers reported that their babies were given Wysoy, a formula based on soya which is used instead of modified cow's milk to avoid the risk of causing allergy. (Warnings have since been issued about its use because of undesirably high levels of aluminium (NCT, 1989).) After the first night mothers were called to the nursery to feed their babies when they awoke, but staff might still feed by bottle if it was judged that the mother needed to rest undisturbed, which in at least one case was against the mother's wishes.

...I said, 'I want to get up.' And they said, 'Well, we don't think you'd better.' I said, 'Well, I want to.' I said, 'Please will you wake me up?' They said, 'Yeh, OK, OK,' and they didn't wake me up...I went through to the nursery in the morning to get him, they have a little

chart and they'd written on it they'd fed him...And I went straight into the-, cos they've got a little office. I went straight in, and I said, 'Excuse me,' I said, 'Why did you feed my baby last night?' And they said, 'Is it your first night?' I said, 'No, it's my second night.' They said, 'Oh well, we should have woken you.' I said, 'Well, will you make sure you wake me tomorrow night?' And they didn't wake me. One of the women, in the bed next to me, she came in and said, 'Your baby's awake.' None of the nurses came in to wake me. So I wasn't very pleased about that.

(Milly:33:2:8)

It was also part of hospital routine for mothers to be shown how to prepare a bottle-feed (which is in accordance with government recommendations (DHSS, 1988, p.53)). However, at these demonstrations they were offered a free tin of formula to take home with them (in contravention of the WHO Code, and government recommendation (NCT, 1986c; Martin & White, 1985, p.xx; DHSS, 1988)).

...the nurse said, 'Come to a demonstration of bottle-feeding.' And all it was, was her just making up the formula, and I was the only one there. And then she said, 'Well, here you are, here's your free sample.'

(Andrea:17:2:33)

Even mothers who had no intention of bottle-feeding accepted the free sample as a stand-by. Only one woman said she refused the offered tin of formula, and another refused

to go to the demonstration because she was in too much pain from stitches to want to walk anywhere more than necessary.

However, despite the hospital atmosphere of dependence on bottle-feeding, mixed breast and bottle-feeding was not treated as an option. Several mothers said they felt they had to sort out their breastfeeding problems before leaving hospital (or soon after), or else change completely to bottle-feeding. Consequently mothers who felt unable to give up giving supplements felt under pressure to give up breastfeeding altogether.

### 9.3.2 Benefits to Baby

Women continued to believe in the ideal of 'breast is best', but when babies did not conform to expectation they were quick to doubt their own personal adequacy as breastfeeders. As mothers felt that the nourishing of their babies was a matter of continuing urgency, they wanted quick solutions, and formula was offered by the hospital as a dependable substitute.

I mean obviously if it's the first time you've done it, it's all a bit unknown. I mean, I read all the theory, but when your baby does not latch on, you think, 'What am I going to do?'...And the trouble is the feeds come around so quickly. You can't say, 'Well, I'll worry about that next week.' You've got to get through so many feeds a day, and that's what I found a bit overpowering at first...It's this feeling that you've got to keep feeding the baby. See, you've almost got to get something sorted out fairly quickly. I'm sure that's why some people, if they were having problems with breastfeeding, go on to bottle-

feeding. Cos you haven't really got time, you don't feel that you've got time to experiment. You've got to get food inside them...

(Samantha:27:2:32)

Mothers who gave bottle-feeds during breastfeeding difficulties frequently found that these feeds went far more smoothly and seemed to satisfy their babies better.

### 9.3.3 Benefits to Mother

The women were trying to learn to breastfeed and care for their babies at a time of physical discomfort and debility following the process of giving birth. Breastfeeding also brought its own pains and discomforts. It is therefore not surprising that no women mentioned any physical pleasures, or discerned any physical benefits to themselves, from breastfeeding during their hospital stay. But there had not been much expectation of these at the first interview, whereas many women had anticipated physical discomforts such as sore nipples and engorgement.

However, the women had hoped for personal satisfaction from doing the best for their babies by breastfeeding, and from 'bonding'. But, again, no mother mentioned experiencing these satisfactions during her hospital stay as a result of breastfeeding. Rather, the time was one of doubt and anxiety as to whether their babies were actually benefitting from breastfeeding.

Some mothers were slow to feel emotionally attached to their babies, whilst others reported feeling extremely attached to their babies very soon or immediately after birth. However, nobody mentioned feeling that breastfeeding was aiding the bonding process. In fact, some women felt rejected by their babies.

But she couldn't be bothered with the effort. It was really-

she did go 'thleh' (expression of disgust) and I thought, 'Am I not washed or something?' I really did. I felt rejected...But when she did take to the bottle so well, I thought, 'I just don't know. I'm not going to take it personally.' But it really did astound me how she went.

(brackets added)

(Priscilla:19:2:6)

Those who tried to breastfeed and gave up had to deal with feelings of disappointment, but were convinced that it was best for their babies as breastfeeding had simply not worked. Those who kept going but had to resort to supplementing with formula, often had to deal with feelings of regret or guilt for not having attained the ideal of breastfeeding.

On the other hand, one of the women who had decided to bottle-feed despite doubts that she might be missing something special in her relationship with her baby, felt the wisdom of her choice had been confirmed by the evidence of the other women's breastfeeding experiences.

...when I had actually come to and was with it the next day...all the other girls were breastfeeding and I felt a bit, you know. Well, I felt, 'Am I doing the right thing? All these other women are breastfeeding. They seem er, babies seem so loving.' It seemed such a loving thing what they were doing, and there was me bottle-feeding. I felt awful...But then the next day I saw all their problems, sore nipples, they were all moaning to high

heaven about everything, about sore nipples and how the milk wasn't coming through properly. And they all had a go at bottle-feeding anyway because their milk wasn't through, they all had to bottle-feed them because all the babies were starving. So they had to give them Wysoy or something...So they all really bottle-fed anyway.

(Fay:21:2:3-4)

#### 9.4 HOSPITAL - CONFLICT AND CONFUSION, DEPENDENCE AND SELF-DETERMINATION

After a few days in hospital the women had to be sufficiently knowledgeable and self-confident to be able to take on the responsibility for the care and feeding of their babies independently in their own homes. But a number of factors converged to hinder the development of the new mother's autonomy. Her lack of knowledge and previous experience made the hospital stay an important learning period, but she was having to learn a new job at a time of physical discomfort and debility. Many aspects of the institutionalised care on the hospital ward cast her in the role of passive and dependent patient rather than active learner, as had her foregoing experience of ante-natal and birthing care. Impersonal relations and lack of staff made asking for help and advice more difficult for the mothers, and giving it more difficult for the staff, and together with the changing and fragmented nature of expert knowledge, led to a lack of consistency and coherence in ideas and practice. Formula was ever-present as a dependable alternative to breastfeeding, and a necessary safe-guard. All the women at times during their hospital stay had apparent reason to doubt the superiority of their breastfeeding abilities over the rival artificial product. To continue breastfeeding in the

face of the various problems which arose in hospital meant overcoming the disempowering factors. It took determination, fortitude and faith that problems would be solved.

Five women, all working-class, had said at the pre-natal interview that they intended to bottle-feed, and none of these attempted to breastfeed. The undecided (lower middle-class) woman (Françoise) did in fact breastfeed, and, despite latching-on problems and being upset by the disapproval of some members of staff for her use of a nipple shield, she persevered and was still breastfeeding when she left hospital. All the women who intended to try breastfeeding did so, but seven of them had given up and turned completely to bottle-feeding by the time they were discharged from hospital. One (Pamela) did so because of medical doubts about the effects of her medication, but all the rest gave up because of the problems they had encountered and because bottle-feeding seemed to work so much better. Of these women, four were working-class and two lower middle-class, which is in line with breastfeeding being associated with higher social status.

When the establishment of breastfeeding calls for qualities such as determination, fortitude and self-confidence, cultural ideas which associate femininity with weakness, dependence and passivity are not helpful. In these circumstances the woman who successfully meets these criteria of femininity is not thereby likely to be fitted to succeed at breastfeeding. However, class cultural differences could make a significant difference and help account for the greater success at breastfeeding of the middle-class women. Apart from the greater cultural acceptance of breastfeeding as normal, middle-class women are more likely to experience self-determination and personal achievement in their education and work careers, and are less likely to be fatalistic. They are also less



likely to feel over-awed by the professional authority of the hospital staff.

This is not to say, though, that the working class women in the study did not show any perseverance. Some said they had 'battled', and ten were still breastfeeding on discharge. Also, it cannot be said that working class women were not actively interested in taking on the responsibility for their babies. Those who decided to change to bottle-feeding justified their decision in terms of what seemed to suit their babies best, and were convinced that breastfeeding simply had not worked in their case.

However, there were two apparent exceptions to the rule of active perseverance being necessary to continuing breastfeeding in hospital. These were the two young working-class women, Mandy (aged 18) and Joy (aged 17). Neither appeared to have much self-confidence, nor active control over their lives. Both had conceived out of wedlock - Mandy's partner had subsequently married her, but she was still living with her own mother; Joy's partner had left her, she was homeless, and her partner's mother was providing her with temporary accommodation while she awaited Council housing. Both seemed to abrogate all responsibility to the hospital staff for themselves and their babies during the hospital stay. They breastfed and supplemented with formula as directed, and seemed to take no initiative at all. Such passive dependence on the staff's supervision meant that they did not suffer the anxieties that the other mothers reported, and they left hospital still breastfeeding. However, this exception to the rule does not extend beyond the hospital, since without the supervision of experts constantly to hand, they rapidly lost confidence and both gave up breastfeeding after about two days.

**CHAPTER 10: RETURNING HOME FROM HOSPITAL**

In *The First Months of Motherhood* Graham and McKee(1979) distinguished a second critical phase in the establishment of breastfeeding: the first two weeks or so after the return from hospital (p.96). Although they found this more significant for mothers who were having their second or subsequent babies (first-time mothers being more likely to give up breastfeeding before leaving hospital), in my study this was also a difficult time for mothers who were still breastfeeding when they returned home.

Out of the 47 women in the study, 35 were breastfeeding their babies on their return from hospital. Five of these gave up breastfeeding altogether by the time their babies were three weeks old, and by the one-month interview four mothers had become 'combination feeders', i.e. offering at least one bottle of formula per day as a permanent supplement to breastfeeding. However, recourse to bottle-feeding as a temporary measure was common: only ten mothers did not report having made use of bottles between returning from hospital and the one-month interview. This was usually to give formula, but sometimes it was to give the mother's own expressed breast milk (see career charts, Appendix 6).

By going into hospital for their confinements the women had been separated from all that was familiar and normal to them. Over a few days they had given birth (a momentous event) for the first time, and begun their initiation into baby-care, completely out of the context of their everyday lives. In hospital they were subject to medical authority, and had professional advisers constantly to hand. They were also shielded from the demands and responsibilities of their home lives. Returning home from hospital therefore involved a number of adjustments. Despite their lack of knowledge

and experience they were now responsible for their babies, professional advisers were no longer constantly on hand for consultation, and they had to incorporate caring for the new baby into the circumstances and duties of their everyday lives. As with the hospital experience, a number of factors converged to prevent the women experiencing this transition to independent motherhood as a demonstration of their female ability and power.

## 10.1 EARLY DAYS AT HOME: DIFFICULTIES AND OBSTACLES

### 10.1.1 Mother's Physical Condition

After the momentous events and unfamiliar surroundings of the previous few days, the women frequently described feeling disorientated when they left the hospital.

I got home, and I was in such a daze. It was really strange. Just coming out of the hospital and getting in the car was like a new experience. I felt really totally disorientated. And then came home, and my husband had cleaned the house from top to bottom, I hardly recognised it...I think so much had happened, and like when I'd gone into hospital the crocuses were out. When I came out all the blossom was out, the crocuses were dead, and the garden looked totally different and everything just looked so different somehow. I think I lost sense of time really while I was in there, and I was very, very tired when I did get back. When I'd got over the initial excitement I realised how tired I was.

(Nancy:9:2:18)

Although the women had been passed as fit enough to leave hospital, many were still suffering physically from the aftermath of the birth. They were not asked to list their complaints systematically, but those mentioned in the course of the interviews included: painful stitches and bruised perineum (10); infected stitches or Caesarean wound (2); uterine infection (2); anaemia (2); raised blood pressure (1); back trouble (1). Also, one mother had to be re-hospitalized for a D & C for 'retained placenta', and another had a fright one evening when she unexpectedly passed 'retained membranes'.

A number of women were also suffering physical problems associated with breastfeeding: sore or cracked nipples (10); engorgement or painful breasts (11); and pain when beginning to feed (7). In addition, two women developed breast infections requiring antibiotics. All these conditions cleared up in time, but it took up to three weeks of painful perseverance and having to resort to such aids as nipple shields, expressing milk to be fed by bottle, and/or supplementing with formula. None of these women gave up breastfeeding because of these difficulties, but their perseverance was a demonstration of their determination to breastfeed.

...it was just really swollen and painful, and I had a red sort of rash underneath here. So she gave me some antibiotics...I was really upset actually. I went into the doctor's and I cried. Cos I thought I might have to give up breastfeeding...(The doctor) advised me to carry on breastfeeding...I was so relieved, but it was painful cos it was sore...It took ages to heal up. It's only just healed up

actually.

(brackets added)

(Pauline:34:2:3,4,5)

I came home and I decided to stop using Kamillosan, and I had some Rotasept spray...I put it on once and I thought, 'Oh, that's really stinging.' I thought, 'That is hurting me dreadfully,' and I thought, 'This can't be right,' because in fact up until then I hadn't really enjoyed it. Breastfeeding had been painful all that time...So I looked and of course I found out that I'd got cracked nipple underneath, sort of under, underneath the bit there. And in fact I had it on both sides. So then I continued to use the shield for quite a while. In fact I used it for about a week when I came home, and then I went back to feeding him normally for about a week, and then the cracked nipple came back again so I used the shield again for another-...But for the first three weeks it was *really* painful.

(emphasis in original speech)

(Vanessa:12:2:7-8)

Apart from discernible physical complaints, the women also suffered a great deal of tiredness and weepiness. Some said they felt exhausted as soon as they returned home, but in any case the women found that caring for a new-born baby was in itself an extremely tiring business, which disrupted their normal routines and sleep patterns.

In addition, as first-time mothers they had no previous experience to draw on and little practical knowledge, and their babies' behaviour frequently varied from their expectations. Everything was new to them, and they were constantly having to make sense of events and work out what to do as they went along. They felt responsible but uncertain (Graham & McKee, 1979; Graham, 1979), and frequently became extremely anxious or frustrated. In their accounts the first few days at home emerge as a particularly chaotic and confusing time.

...when I first got her home both me and my husband spent-, we just spent a hundred per cent of our time sort of feeding and changing her and dressing her, it seemed to me. I mean, now I seem to have a lot more time to do things, so I don't know quite what happened those first few days. I can't think how we just managed to spend all our time feeding her and changing her, but I'm sure we did, and I thought then, 'Good grief, when am I ever going to do anything else if it's going to be like this?'

(Tabitha:4:2:33)

But even at the one-month interview it was common for mothers to say that they were living 'one day at a time' without any clear sense of direction.

I spend my life calculating when-, particularly when there are people coming to the house, whether he's likely to be demanding a feed. Last Wednesday I had the health visitor coming, someone to collect our old car, and somebody else as well, and I thought, 'Well, I'm not going

to manage to weave a path between all three of those.'

But in the event we did, just about...It's certainly a big change, cos one's whole life is now revolving round him and what he's doing. He demands attention so frequently one can't really forget about him for a minute...I'm taking this one day at a time, and not even looking forward to the time when he'll sleep all night because if I do that he's bound to want to get up longer, so I really just take one day at a time, each three hours at a time really, and I haven't started to think about anything further.

(Valerie:13:2:15,17,18)

#### 10.1.2 Autonomy and Dependence

Despite being anxious about taking on the care of their babies in their own homes away from direct access to expert guidance, overwhelmingly the women felt relieved to leave hospital and be back in their own territory where they could get on with sorting out their new responsibilities for themselves in the context of their own personal circumstances and relationships. They wanted to be independent, and yet through their lack of knowledge and anxiety they felt in desperate need of help and reassurance. Once again their sources of advice and support have been categorised as 'expert' and 'lay'.

#### Expert Sources

Although discharged from hospital, the new mothers and their babies were not immediately discharged totally from medical care. Within a day of discharge from hospital they were visited by a midwife who checked both the mother's and the baby's well-being. Thereafter the mothers received a daily visit until ten days after the birth.

In a few cases the midwife continued to visit for a few more days to check on aspects of the mother's condition. Between eleven and fourteen days after the birth the Health Visitor called, and again about a week after that, and some women had received further visits before the one-month interview.

In general the women appreciated these visits, which gave opportunities to chat and ask questions in their own homes. However, there were limits to the usefulness of the service reminiscent of those encountered in hospital in having to rely on busy strangers with little continuity of care.

I had four midwives. And each one came in and said something different, and I got quite desperate with them all, and thought, 'Just all go away and leave me alone.' And then I had the first one I'd had, who I did get on with, came on the fifth day, and she was very nice. The other three just got me into a faff really.

(Gwen:44:2:10)

One of the problems with a brief visit is that the expert is unlikely to be on hand when most needed. A few women used the telephone to ask for advice at times of high anxiety. This could be the hospital (soon after returning home), or the community midwifery service, or, later on, the health visitor.

...he was very, very fretful that first night. I didn't know what to do with him. I think it was because everything was strange for him, and he probably felt I'd sort of got excited and then sort of didn't know what to do with him, so our first evening wasn't a great success.



(Interviewer: So what did you do?)

Um, cried. I tried everything, changed him, fed him, gave him water, winded him, you know, went through the whole sort of list, and he still wouldn't settle, so I rang the hospital and said, 'Have I missed anything out?' sort of thing, 'Is there anything else I can do?' And she said, 'Oh, I think it's probably just his first day at home' sort of thing, new surroundings and everything. And then he did settle down, and went to sleep.

(Nancy:9:2:18-19)

However, many women said they felt too shy to telephone strangers for what could be judged trivial points, and a nuisance at odd hours.

Some women were visited by their GPs after their return home, or even visited the GP's surgery if particular problems occurred. But Gps were not generally consulted for advice on everyday baby-care and feeding, and did not offer it.

Books and leaflets were frequently referred to, but usually only to look up information for particular worries as the women found they no longer had time for reading as such. Again, the usefulness of written sources was limited. The information was too generalised and impersonal: it was not addressed to particular circumstances and worries, and the advice therefore seemed either not specific enough or not totally relevant. It was also limited, and could leave women feeling confused and anxious. They preferred being able to talk things over with someone who could reassure them with reference to their particular baby.

For instance, Tabitha was worried about whether her baby was feeding enough:

...a book, baby care book, Miriam Stoppard baby care book, and quite a few leaflets I was given on breastfeeding while I was pregnant, when I went to the classes and that sort of thing... basically to see if they all agreed with each other and which one would give the largest amount of time she could go without food. But a lot of them don't actually commit themselves. I think most of them seem to say something like every baby should be feeding every three hours at one month and every four hours at three months and that sort of thing. I don't know whether I find it helpful or more worrying. I don't know whether I'd be better off not having read them at all actually. I'm not sure cos when you do read, you think the baby ought to conform exactly to what it says in the book and you're worried if she doesn't... but to be fair most of the books say every baby's an individual and they'll all vary, so, but it doesn't say how much they can vary before you need to rush them to the hospital and that sort of thing...

(Tabitha:4:2:30-31)

Most of the women had begun to visit the well-baby clinic before the one-month interview, and the rest all intended to soon (except for the mother who was having chemotherapy who had been advised against it but who continued to receive special medical attention anyway). At the clinic the babies were weighed, there was a health visitor to discuss any problems, and periodically a doctor would examine the baby. On

the whole mothers valued this service as a source of reassurance, although women of all social classes often expressed surprise after their first visit that it had been so brief and that more interest had not been taken. Mothers often raised queries, although sometimes they were disappointed that the health visitor was not more helpful on specific points. The ambiguity between the women's desire for independence and their felt dependence on expert advice seemed to be a factor here. Some women, particularly working-class, complained that the advice was too vague because they were being told to do what they wanted, while a few working- and lower middle-class women found the health visitors too bossy. Some mothers were put off by a lack of privacy for such discussions. The main source of reassurance therefore seemed to come from having the baby weighed, which was of particular significance to breastfeeding mothers.

Well, I mean the only thing is that you never know how much they're taking when you're breastfeeding. I mean you can't measure it at all. So, the first week he gained six ounces which was all right, sort of thing. I mean last week he gained eleven ounces which was very good, so got no worries on that score at all.

(Nancy:9:2:25)

Members of the NCT had contact with a breastfeeding counsellor, and frequently also their ante-natal class teacher, soon after returning home. It was NCT policy that new mothers should be contacted by telephone at this time, and for this purpose postcards were issued at ante-natal classes so that mothers could notify the NCT when they had given birth. Some women initiated calls to their counsellors for help with particular problems. Often the help was practical - loaning or supplying things like

electric breast pumps, nipple shields or nursing bras, for instance. The women also appreciated the opportunity to discuss their particular problems, and the emotional support, although again they had to interpret and apply the information to their particular needs.

...she was sweet. She wrote out a list of reasons why my nipples might be sore and suggested solutions. In fact, I mean I'm sure it wasn't soggy breast pads, or it wasn't that-. It was caused by the fact that he couldn't latch on when I was so engorged. She was just very helpful and nice to talk to. And I said that I was limiting him very much to minutes, which in a way is not what the NCT suggest, and she said, 'Well, if that's how you're happy and he's happy, then do it.' It was more or less somebody encouraging, and I had more chats with her in a way because the breast pump broke down.

(Audrey:10:2:40)

Although the NCT breastfeeding counsellors were strongly committed to encouraging breastfeeding, like the hospital staff they avoided applying pressure, and supported decisions that the women made including giving bottle-feeds.

Despite being members of the same organisation, and the fact that breastfeeding counsellors emphasized their availability at all hours of the day or night, the mothers still felt reluctant to telephone at odd hours or to risk being a nuisance.

### Lay Support

For most of the new mothers the principal supporter at home was the baby's

father, and nearly all the fathers had at least some time off work during the early days at home to give support to the new mother, and to begin to take on the role of father. Obviously the fathers could not breastfeed, but they could help with other aspects of baby-care. During the early days they also relieved the new mother of everyday household chores normally done principally by her, such as cooking, cleaning, washing and shopping.

Although the women looked on the fathers as co-parents, when it came to baby-care and breastfeeding they were even less knowledgeable than the mothers, except for one father who had had two children by a previous marriage, and whose experience was useful to his wife.

...she was sick for the first time, and it came out, you know, a gallon of it. I thought, 'God, whatever's happened here?' and I thought, 'Oh dear, I hope she's all right.'...that's where my husband's very good because as you know he's got two boys from his first marriage, and he's sort of a calming effect. He said, 'Oh, they all do that.'

(Anneka:5:2:19)

But even he had had no experience of breastfeeding since his sons had been bottle-fed. However, the fathers were an interested party to share problems with and help seek solutions.

One night we thought, 'He's got bronchitis or pneumonia or something,' cos he was wheezing away like anything...I mean at three o'clock in the morning you imagine all sorts

of things. My husband, sitting up in bed, thumbing through the book (baby-care manual)...It didn't reassure him. It did me.

(brackets added)

(Nancy:9:2:27)

A few mothers said their husbands seemed uncomfortable about performing some of the tasks of baby-care, e.g. nappy changing or bathing, but in general the new fathers were pleased to be involved in the care of their children. All the breastfeeding mothers felt they had the approval of their husbands who shared their belief in the superiority of breast milk. On the other hand, none of the women who bottle-fed or gave up breastfeeding felt any opposition from their husbands. In fact, when breastfeeding problems arose the mothers did not expect their husbands' support to be unlimited. They still had primary responsibility for housework which included maintaining a comfortable home and providing meals etc. for their husbands, and when persevering with breastfeeding meant continuing disruption of normal domestic routines the women felt guilty. Also, with bottle-feeding the husband can take over feeding, thereby having a direct involvement with the baby and solving a feeding problem himself, whereas breastfeeding inevitably puts the mother centre-stage with the husband having to play a supportive role to her. The women were already conscious of their husband's potential jealousy of their breastfeeding ability, and they often cited as one of the beneficial effects of having temporary recourse to bottle-feeding, the fact that it enabled the fathers to have a go at feeding. On the whole middle-class fathers seemed more willing (or able) to act in a supportive role, and their wives seemed to feel more able to make demands of their husbands for support, although middle-class women were not without

this sort of anxiety, and many of the working-class fathers gave considerable amounts of help.

He has a feed and then he's there all night. But the trouble is I can't get any dinner or anything. My husband doesn't come home till half-seven. Meanwhile I haven't eaten, which is worse on my milk. So he has to down tools, make the meal, feed me, wash up. I feel that I'm not fulfilling my duties. Something I've always done.

(Social class I)

(Marcia:35:2:26)

I done it up until she was about two and a half, three weeks old...But I mean really the crunch came, was one night I was here and I was just so tired, and I think your brain goes a bit when you've had a baby, doesn't it? You're a little bit sort of, you know, sensitive, and I mean it was something really silly, and I was changing her here and she weed. And it was all up her back and everywhere, you know, all up her Babygro and everything, and of course it started all running in front of the settee, and I'm trying to catch it, and my husband's just sitting here looking at the telly, and I'm going, 'Well, help, help,' you know, and trying to mop it up, and he was going, 'Oh god, oh god!', you know, and I burst into tears, and she was screaming, and I just held her, and she

had nothing on, and just held her, and we both just cried, you know. And he said, 'This is ridiculous.' He said, 'You're just getting so tired because you're being so pig-headed about this breastfeeding.'...And I said, 'Well, I want to do it,' and 'I want to do it.' And he said, 'Well, what are you going to do when I go back to work and that?' He said, 'Why don't you just try and put her on the bottle?'

(Social class III)

(Barbie:30:2:20-21)

Most of the women also received help and support from their own mothers and/or (less frequently) their mothers-in-law. Often the baby's grandmother came to stay for a few days, or, if she lived close enough, she could call in every day. This latter arrangement was more characteristic of the working-class than middle-class women, and four working-class women (Joy, Mandy, Fern and Michelina) were actually living in the same household as one of the baby's grandmothers at the time of their discharge from hospital.

The babies' grandmothers were able to give a great deal of help and support to the new mothers, especially with household chores. But for various reasons the support seems to have been less satisfactory for middle-class women than for the working-class. For instance, when the grandparents had to come from a distance and stay with the new mother, this often took place after the first few days at home when the baby's father had gone back to work. There could be some ambiguity as to whether they were there to help the new mother, or to see their new grandchild and be entertained by the new



mother as her guest.

It was very helpful in that she did all my housework and ironing and washing and what have you, but I found that I didn't get the rest that I needed because she was always buzzing around and she was also going out meeting old friends that she hadn't seen for quite some time. She was talking to me a lot about her friends and I just wanted to sit there quietly like I had been the previous week, so in some respects it didn't quite work. Probably sounds ungrateful, but I think I would have preferred to have been on my own.

(Sheena:6:2:29)

These grandmothers were obviously experienced mothers, but on the whole middle-class women were able to make less use of this experience than working-class women, especially when it came to feeding. Some of the working-class women had very close relationships with their mothers anyway, but even so the working class women were less likely to see the grandmother's ideas as out-of-date, as they shared more the assumptions of the medical model which the older generation had learned. Clashes occurred for some of the middle-class women who were trying to apply the ideas of the 'natural ideal', especially with regard to demand feeding. The older generation often interpreted having to feed more often than four-hourly and for longer than twenty minutes as a sign of inadequacy.

The first week we were looking all the breastfeeding bits up, and most of them, the books now seem to say, when

your baby is hungry, feed him. But my mother-in-law is something else. She was saying, 'Oh, when Terry was a baby he used to go four hours without a feed and then I'd feed him and then put him-, wind him, put him down, I'd never hear anything from him for the next three hours.' And I just can't get anywhere near that, and I don't know how she did it. I can't see that the psychology of babies has changed that much, or whether I've got a difficult one. I don't know.

(Marcia:35:2:26)

I think people are very good actually. They don't actually give you advice unless you ask. But the only thing is it's been my mother-in-law and my mother saying, 'Oh, he's putting on all that weight, oh, he'll be taking so much from you, perhaps you ought to start him on solids now.' And I said, 'You can't go on solids at six weeks!'

(Vanessa:12:2:29)

My mother, I think, thought I was being a little bit mad in my goings on. I got the impression. She didn't actually say so, but she obviously thought that I wouldn't be able to breastfeed satisfactorily...and she kept saying, 'Oh, you'll have to give her a bottle,' and that sort of thing...

(Sarah:2:2:34-35)

The lack of this sort of clash between working-class mothers and their own

mothers meant that they were likely to come to the same conclusions about the need for bottle-feeding. Twelve of the nineteen working-class women were bottle-feeding by the one-month interview, and their mothers and mothers-in-law were able to give direct help and support when necessary, including sometimes feeding the babies for the mothers. But of the seven remaining working-class breastfeeders, three did derive help with their breastfeeding from the older generation mothers. Pauline's mother was a nursing auxiliary in the maternity ward and was used to helping mothers to breastfeed. Michelina suffered a great deal of anxiety at first about her baby's frequent demands, but her Italian mother-in-law was an experienced breaster who gave general reassurance and explained the principle of demand and supply. But Cynthia, who had felt confused by the advice given in hospital, was able to carry on breastfeeding because the medical model type ideas of her mother made more sense to her and provided a coherent framework to work to with explanations for her baby's behaviour which did not implicate her milk. She therefore adopted a four-hour feeding schedule, and interpreted fretfulness between feeds as 'wind' or 'exercising his lungs'. In practice she applied a certain amount of flexibility and may well have ended up feeding similarly to some of the mothers who were trying to interpret 'demand feeding', but she felt happy that she now had a basic routine.

I have tried to get it to like a six, ten and two, six and ten.

But then there are times when he'll wake up, say he wakes at four in the morning, I'll feed him then, but then we do tend to catch up so that by the end of the day, it's around about six o'clock. We're right at that feed. So it's a bit of both really. But I don't feed him every time he wakes

up and cries.

(Cynthia:14:2:11)

The meanings supplied by her mother's advice meant she was relieved of much of the anxiety that many of the mothers continued to feel over conflicting ideas from the medical model and natural ideal, i.e. believing fretfulness was a demand to be fed but that babies should be satisfied for about four hours.

A certain amount of support was given by other experienced mothers of the same generation as the new mother. For some of the working-class mothers there was practical support from sisters and sisters-in-law such as help with housework, baby-sitting, setting up the steriliser and feeding the baby. Middle-class women were independent of this sort of help, but sometimes conferred with peer group mothers for information or to compare experiences. They often felt more comfortable discussing matters with mothers whose experience was recent or current, feeling it to be more relevant and up-to-date than that of the older generation because they were 'in the same boat'. However, much of this sort of support would come through reunions with antenatal class-mates or getting into a support network of similar mothers, and this sort of contact was seldom made until after the first few weeks home.

In general then the mothers' own lack of knowledge was not adequately compensated for by easy access to help and advice from experts or experienced mothers. Those working-class mothers who did have experienced lay support were unlikely thereby to gain useful help and advice for breastfeeding.

### 10.1.3 Breastfeeding Difficulties and Conflicting Advice

In trying to establish breastfeeding at home the mothers had to apply the ideas they had gained in the light of their interpretations of their babies' behaviour. They

were hindered by conflicting ideas and the lack of a coherent framework of ideas to work to.

### Positioning and Latching On

There was much evidence of mothers and babies still learning the practical skills of positioning at the breast and latching on. But the mothers did not seem to receive much help with this, and those that overcame the problem often did so solely by their own perseverance.

For instance mothers suffering sore nipples usually persevered by using nipple shields and expressing until the soreness had eased enough to put the baby back on the breast, reverting again to nipple shields if necessary until eventually they were able to feed freely from the nipple. But Simone was helped when one of the visiting midwives pointed out that the baby was pinching her nipple with pursed lips instead of milking it with open lips and tongue. Recent suggestions that medical personnel do not pay enough attention to correct latching on, and are often unfamiliar with the difference between sucking from a breast and a teat, are borne out by the fact that this pursed-lip latch had not been pointed out to this mother before, and that she herself had not recognised it despite being a nurse who had worked in a special care baby unit helping mothers with breastfeeding. In fact, Simone remarked on how her training had helped her in all matters of baby-care except in this, which made her feel 'really stupid'. (Simone:20:2:12)

Lack of skill at positioning and latching on could also have contributed to babies not seeming to want to feed at the breast, and/or not seeming satisfied by the feed which sometimes led mothers to believe their milk was inadequate (although this could have been compounded by medical model type expectations as to how long a baby should feed

and be satisfied for). In the following two examples, the two young working-class women, Joy and Mandy, both gave up breastfeeding two days after returning from hospital. Both said they found breastfeeding difficult and the baby seemed unsatisfied. Both tried expressing their milk so that they could feed it by bottle and see how much was actually consumed (although neither realised that expressing milk was likely to yield less than a baby's sucking). They found it easier to feed the baby by bottle, but their doubts about their milk supply seemed confirmed by the small amount they were able to express and the baby's still not seeming satisfied.

Interviewer: Why did you start expressing?

Joy: I don't know.

Interviewer: I mean was it because you were engorged and you wanted to relieve it, or was it because you wanted to see the milk?

Joy: I just wanted a rest really, I think. I found it easier.

Interviewer: You wanted a rest?

Joy: Yeh.

Interviewer: What, easier to express it, put it in a bottle and then feed it?

Joy: Yeh.

Interviewer: Is it then actually putting the baby to the breast that's hard work?

Joy: I think so, yes. And keeping her on.

Interviewer: Why, does she slip off or something?

Joy: Yeh, they do...And you don't know how much

they're getting. I just didn't like it.

Interviewer: So when you saw the milk in the bottle after you'd expressed it, was that reassuring or not?

Joy: Um, no.

Interviewer: Why was that? Because it didn't seem much, or what?

Joy: No, there wasn't much of it.

Interviewer: Did it seem as much as a bottle-feed?

Joy: No.

Interviewer: I mean, did that worry you, that she wasn't getting enough?

Joy: Yeh, it did. But I mean I know that she's getting enough now (after changing to formula).

(brackets added)

(Joy: 36:2:25-26)

I was expressing it into a clean bowl, sterilised bowl, then putting it in the bottle, and he seemed to take it like that, but it still wasn't satisfying him, so. ...I didn't know whether to put him on the bottle, or keep trying him with the breast. I kept doing it as far as I could, but then I realised that he wasn't satisfied, and I wasn't satisfied knowing that he wasn't getting enough, so then I put him straight on to the bottle.

(Mandy:28:2:7)

A number of women saw their difficulties with latching on as the baby's problem, and remarked on how their ante-natal education had led them to expect problems for themselves from breastfeeding, but had not prepared them for the baby's difficulties.

I suppose I thought it would all be a lot easier than it was actually. Thinking back to the ante-natal classes when they showed us that film on breastfeeding, I don't seem to remember them mentioning any of the problems that I've had really. Cos the main problem that I had was actually getting her to take the breast, to latch on to the nipple and to actually start sucking, and I don't remember that as ever being talked of as being a problem, and when I've looked it up in books, it says reasons for refusal, refusing a breast are-, and it says the only real reason is cos she can't breathe, cos the baby can't breathe, and I know very well that she can breathe, her nose isn't blocked, she can breathe quite easily, but she still won't take it. The problems they seem to talk about are engorgement and sore nipples and cracked nipples and that sort of thing.

(Tabitha:4:2:36)

...it's been a lot more difficult than I thought, and I can see why a lot of people choose bottle-feeding...I didn't realise that things like positioning-, and that it was difficult from the baby's point of view as well to suckle. That is what is difficult, isn't it? I mean I always realised from



my breastfeeding talk at the NCT that it wasn't a straight forward thing, but I was thinking of it more from the mother's point of view. I hadn't really appreciated that the baby was going to find it difficult...

(Irene:3:2:34-35)

### Feeding 'On Demand'

Within the logic of the 'natural ideal', when babies are constantly carried around on their mothers' bodies with free access to the breast, their sucking may for some portions of the day seem more or less continuous rather than divided into separate 'feeds' like meals. The mothers in the study had all been exposed to the idea of being responsive to the baby's demands, and most of the breastfeeders were trying to put this into practice, but they still basically thought in terms of separate feeds which ought to satisfy the baby for about four hours. 'Demand feeding' was therefore usually interpreted as being flexible within a three-to-five hour pattern. A feature of the one-month interview was the way that the mothers were constantly calculating the interval between feeds and felt that they ought to have feeding in a roughly four-hour pattern. In the following two examples the babies began crying during the interview, and I witnessed first-hand the calculations involved in deciding whether to feed or not. If the interval seemed too short they felt anxious about feeding again so soon.

(talking to baby who is becoming fretful) Um, look darling, what's the matter, what's the matter, come on. Um? Um? What time is that? Is that-, can't see it. Sorry?

(Interviewer: It says five past three.)

Five three. When did I feed her? Two hours. You shouldn't be hungry yet...(interview continues while baby continues to fuss, mother describes different remedies she has tried for fretfulness)...bumping on knees gently, drinks, cuddles, music, she loves music actually. That usually calms her down. She also enjoys lying on the changing mat on the floor. We've tried taking her out in the car when she's fretful, but it doesn't really work. Nor does taking her out in the pram. She just screams... You're not happy, are you darling? Mmm?

(Interviewer: Does she have a dummy?)

We tried her with a dummy but she won't take it. I think what she needs is me, actually. Are you hungry again? You shouldn't be. Been two hours. Been two hours. Are you hungry? Yes? I don't know if you are or not. Shall we try putting you down? Mmm? Eh? (Baby's cries obscure mother's speech. Mother puts baby to breast. Baby stops crying and sucks.)

(Andrea:17:2:30-31)

...do you know what the time is, Celia?

(Interviewer: No.)

As I say I am trying to make him go a bit longer at the moment, so hopefully

(Interviewer, retrieving watch from purse: Four forty

three.)

Now, what time did we feed you? Um, can you remember, cos I can't. Um, now, what time was it? Er, this is where the whole system goes to pot, isn't it? Um, I think-. Well, I know we fed you at quarter to seven this morning, start from the b-, quarter to seven, quarter to eight, quarter to nine, quarter to ten, quarter to eleven, half eleven it must have been. So, half eleven, half twelve, half one, half two, half three, half four. Well, have we fed you in between? Don't think we have actually. Oooh, must be starving.

(Vanessa:12:2:34-35)

Even mothers who did not let the interval inhibit or worry them, and found themselves feeding on and off for long periods, still talked in terms of the normality of feeds at set intervals.

...there were some feeds when she was crying herself into the next feed. So she would start off, say, at midday, twelve o'clock, and I would feed her, and on and off sleeping, feeding, sleeping, feeding, crying. By three o'clock in the afternoon she still wouldn't have slept properly, and I didn't know if I was topping up my twelve o'clock feed or if I was starting off my three o'clock feed...

(Connie:23:2:17)

Connie was unusual in that she did not interpret such feeding as an indication of inadequacy in her milk, merely as a nuisance. Most mothers did have such doubts when their babies demanded sooner than three hours, and although most of them knew that more feeding was the way to stimulate milk production, this did not seem instant enough and many felt the need to 'top up' with formula. Also, medical model ideas of 'over-feeding' or 'sucking on an empty breast' leading to digestive problems or wind worried some women.

One evening he really yelled and yelled...I fed him at sort of seven, and at about half-past nine he was still absolutely scarlet yelling, and I rang up the maternity bleep, and said, 'After this sort of time should I feed him again or do you think it would make it worse? Do you think it's wind, or after that sort of time should I feed him?' And they said after two-and-a-half hours they recommended feeding him again, and if he still didn't settle give him some water, and then if still doesn't settle just leave him in his cot to yell himself to sleep because, perhaps because we're getting aggravated, he is.

(Audrey:10:2:26)

I'm happy to feed her when she cries, when she wants to, and it worked sort of reasonably well in hospital. But because she's been colicky the health visitor said not to feed her more than three hours, between three and four hours. And she doesn't always want that, you see.

Sometimes she wants feeding two and a half hours, two hours, and it has caused problems because I thought, 'Well, if it's causing colic for her to feed too often, overloading her stomach-', but then she's distressed because she's hungry, so what do you do? So it's a bit of a dilemma.

(Andrea:17:2:14)

On the other hand, when babies slept for more than five hours the mothers worried about whether their babies were getting enough nourishment to sustain them. In the first few days mothers frequently woke their babies, even at night, for this reason. Soon the mothers were wishing their babies would sleep longer at night so that they could themselves have a few hours' undisturbed sleep, but time and again the mothers said that their reaction when their babies first slept beyond the expected time at night was anxiety.

...we woke up in the morning and we looked at the clock and he'd gone for-, it was over six hours he'd slept, and I thought, 'Oh my god, is he still alive?' Because we've got him in with us in the carry-cot, and I sort of leapt out of bed and peeped over and I saw the blankets moving.

(Donna:47:2:9)

...about a week ago she went for eight and a half hours without anything during the night, but I didn't know whether that was normal or not. I've since asked the midwife and she said it's OK to let her go that long during

the night as long as she feeds quite frequently during the day. But I hadn't meant it to happen, it's just that I just didn't wake up.

(Tabitha:4:2:23-24)

...when we got home I would set the alarm clock to wake up to feed her, and sit and shake her awake for about twenty minutes because she really was so sleepy, and in the end I spoke to what's her name, Marilyn (NCT breastfeeding counsellor), cos she rung up, and I said, 'Look, do I have to wake her up at night?' cos there are so many contradicting stories... and she said, 'Well, you have the perfect situation, she'll wake up if she wants it.'

(brackets added)

(Anneka:5:2:6)

Thinking in terms of separate feeds like meals meant that the mothers rarely took a view of feeding over the whole twenty-four hour period or took account of whether long periods of sleep were balanced by active periods of frequent feeding. The reasoning in the following two examples was rare at the one-month interview, and in both cases (one a bottle-feeding mother, and one the breastfeeding mother quoted above) was adopted only after initial anxiety:

...she has a fretful period between sort of six and ten at night, and sometimes she can have two bottles in those four hours, because she seems to make up for what she doesn't have, during the evening...When I spoke to the

Health Visitor, she said, 'Well, she's obviously making up for going through the night.'...First of all when I came home I couldn't believe it. I put her down, I thought, 'You can't still be hungry,' and, 'Waaaah!' she was, and we tried another bottle. I said to my husband, 'See how much she's going to take of this. I'll have to feed her.' And he said, 'She's still hungry.' So she had another. In all she was taking five ounces, or ten ounces in four hours. But they didn't seem too unconcerned (sic). It worried me a bit at first. I thought, 'Can you over-feed?' But they said, 'No, if that's what she wants and then goes all through the night, she obviously makes up for it.' So, they seemed to think it was OK. So getting on quite well at the moment.

(Tracey:26:2:4)

...she has a sort of wake period from about six o'clock in the evening to about sort of eleven where she is on and off, on and off, so we keep her down here and feed her when she wants feeding, and then it is as if she stocks up for the night really, and then she sleeps, which is very good. So, it suits me and suits her.

(Anneka:5:2:6)

Of course, bottle-feeding mothers could take comfort from being able to measure exactly how much their babies had consumed and thereby reassure themselves that their

babies were being nourished - although for some bottle-feeding mothers this could be a source of concern if their babies seemed reluctant to take the set amount at one feed, and appeared to want too much at another. There were accounts by bottle-feeding mothers of trying to force their babies to take the full feed when they had seemed to lose interest after a small amount. The idea that babies should have regular amounts of feed was echoed by the breastfeeding mothers who time and again described 'good' feeds in terms of the baby sucking steadily for at least a minimum amount of time. Here is Anneka again (an NCT member), recounting her difficulty in reconciling conflicting ideas on what constitutes a proper feed.

Well, it's very stupid cos I'm contradicting myself here, but I keep looking at the clock thinking-, just to have a sneaky look and see how long has she been on. So I suppose to me a good feed is if she's been on for about seven or eight minutes on one side and then again six minutes on the other. I'm happy then, but I mean if she's on for three minutes on one and four minutes on the other she's happy too, but I just think, 'Oh, I wish she'd have a bit more.' But you just got to keep reminding yourself to say, 'Well, she's had enough, she doesn't want any more, and she'll wake if you (sic) do.' That's the bit I think that takes you a bit of getting used to, because apparently - I mean you probably know - but apparently this ten minutes on either side was due to somebody saying that that's how long a bottle took to finish, so I try to go into the room to



feed her without my watch on, and I sit there thinking, 'How long, I wonder, how long?' You know, stupid. So I keep my watch on now anyway...

(Interviewer: So what's a bad feed?)

...it's sort of when she keeps going on and on, on and off, on and off. Sort of she has two sucks and then she goes off, and then she has another couple of sucks and then she goes off and fiddles around and plays a bit...Sometimes she's dozing off, but a lot of times cos she's playing she just likes to lie there and play and she looks around, maybe she can see, but I mean she certainly turns her head and looks around in the room, but not concentrating on feeding. So she can't be starving I suppose at that point, but that to me is what I call not such a good feed...I just want to make sure that she's actually getting something in her at that particular-. Then I think, well, she might go to sleep for-, cos she's a fairly sleepy baby as you can see-, she might go to sleep a couple of hours so she might actually miss out on-. I mean, it's very difficult I think to get away from the rigid sort of things that you read in books that, you know, every four hours and whatever, you should do this and you should do-, and it's very hard to get enough confidence I suppose it is, to think to yourself, 'Well, it's all right, that's all she wanted at that time,'

even if it is only two minutes.

(Anneka:5:2:25-26)

Some mothers remarked on their babies slowing in their rate of sucking as if they were falling asleep, and yet waking up and crying if removed from the breast. That babies might want oral gratification at the breast was sometimes recognised, but suckling was mainly seen as a means of delivering nourishment. A few mothers said they had found that suckling was useful as a comforter especially to get their babies off to sleep, but on the whole this was not seen as a reason in itself for putting the baby to the breast, and the perception of their babies as 'sucky' was more likely to stimulate the mothers to try their babies with dummies.

Altogether then, both in the practical difficulties the women faced in getting their babies to feed and in the anxieties they experienced as to the adequacy of their milk, the legacy of the medical model was still apparent through their lack of understanding of faulty latching on and its consequences, and in their continuing assumption that feeding should follow an approximate four-hour pattern of discrete feeds.

It would hardly have been surprising if the mothers had not experienced anxiety when they were trying to learn a new physical skill without much previous knowledge of their own to guide them, but the juxtaposition of conflicting ideas from the medical model and the natural ideal was also an important factor in their difficulties in overcoming problems with positioning and latching on, and in deciding how much to feed.

## 10.2 THE FULFILMENT OF EXPECTATIONS

Taking again the categories used to classify the advantages of breastfeeding mentioned by the women at the first (pre-natal) interview, how far did their accounts of

their early experiences of feeding at home bear out these expected (or hoped for) advantages?

### 10.2.1 Breastfeeding as a Norm

In the first interview breastfeeding emerged as more of a sub-cultural norm for middle-class women, and this seemed to help them in persevering with breastfeeding in the early days at home. Whereas working-class mothers tended to feel that significant others would judge them as merely stubborn if they persisted in the face of breastfeeding problems, there was evidence that middle-class mothers were more fearful of being judged failures if they did not overcome these problems.

I suppose I partly felt pressure from him (husband) as well to breastfeed, and from everybody else I suppose, my parents and relatives partly. I think it would be much easier to give up if, say, my mother hadn't breastfed me or if my sister-in-law hadn't breastfed her babies, and that sort of thing.

(brackets added)

(Tabitha:4:2:28)

But formula was still viewed as a reliable alternative, and a necessary stand-by in times of doubt about the adequacy of the mother's breastfeeding efforts. As has been seen, many breastfeeding mothers had recourse to formula in dealing with problems such as sore nipples and apparent milk insufficiency.

Bottle-feeding was also a necessity for many mothers in coping with the problems of the social unacceptability of breastfeeding in public. In hospital breastfeeding had been an approved practice, but once the mothers left hospital even those most committed

to breastfeeding as the norm recognised that it could cause social embarrassment and disapproval, whereas bottle-feeding was an acceptable practice in public. Another reminder of the view of breastfeeding as culturally polluting and animal-like came from one of the mother's husbands who was present during the second interview.

Saw a woman walking round Waitrose a few months ago,  
breastfeeding in Waitrose, walking round with the baby  
latched on her bosom. Yeh, like a monkey, you know. I  
thought the food shop's hardly the right place to do it.

(Pauline:34:2:17-18)

(Since hearing this I have become conscious of people eating and drinking in supermarkets, and often see children, and sometimes adults, wandering round the shelves consuming items of food (chocolate bars, crisps, buns, fruit, ice-creams, etc. etc.) and drinks from cartons or cans. I submit that behind Pauline's husband's allusions to contamination is the fact that breast milk is a body fluid taken by the baby directly from the body, whereas with the other foods and drinks being sold, and consumed, in supermarkets, the raw materials have been converted into cultural products.)

Another example of a mother feeling personal embarrassment about bodily functions also cropped up in the second interviews. (The hospital had represented a safe haven for breastfeeding away from everyday social life.)

I didn't mind doing it in the hospital cos it wasn't  
embarrassing, but when I was at home I wouldn't do it.  
I'd go up to the bedroom and do it...that's something that  
I just didn't fancy. I thought it was my-, it was just me,  
you know?...I mean I'd already lost all my dignity in

labour, so I thought I'm going to keep that. It's the only thing I've got left.

(Joy:36:2:29)

But many women explicitly pointed out that their inhibition was not because of their own embarrassment, but stemmed from their fear of the reaction of others.

I mean I'm not embarrassed about it, so it doesn't really bother me...I suppose just in public places, I don't know if I'd feel that relaxed about it, cos you get an awful lot of criticism from other people, don't you, from sort of older people I think can criticise you for it.

(Vanessa:12:2:36)

...I mean I wouldn't get embarrassed. I mean, as far as I was concerned, if I was in W--- (town centre) and he needed feeding, I'd sit down on a bench and just do it, but other people would get embarrassed I think, so I just wait till I get home. (brackets added)

(Milly:33:2:25)

During the early days the new mothers remained in the privacy of their own homes, although even here they might have to take evasive action when visitors came, and feed in a different room. But as the days went by the women did begin to venture out again, and want to take part in social activities. Even going out shopping for any length of time had to take account of possible demands to be fed, and this was one of the ways in which bottle-feeders felt they had an advantage. Here the experience of a breastfeeding mother is followed by that of a bottle-feeder.

...I was in Mothercare, and it was her feed time about half-past four, five o'clock, and at about twenty past four she started to turn and sort of give a little yell. So I said to my sister-in-law, 'I'm going. I'm leaving you.' I said, 'If she starts crying, to feed her, what am I going to do?' I said. If it's a bottle-feed, all right, I could have just sort of sat down somewhere and bottle-fed her, but, me breastfeeding, 'What am I going to do?' I said, 'I've got to go.'

(Michelina:22:2:28)

We went down to Kingston (shopping centre)...and of course you can go to a coffee shop when she needs feeding, and you can have something as well as feeding her, so it wasn't too bad.

(bottle-feeding) (brackets added)

(Lorraine:15:2:8)

Some breastfeeding mothers bemoaned the lack of facilities in public places for feeding in private.

...there aren't ever any places for mums to feed, and I've noticed that since we've been driving around a bit, especially down in the town, there's nowhere to feed at all. If I didn't have the car then I'd have been stuck. I'd have been stuck on the road-side and fed her...There's absolutely nowhere, apart from toilets...and that's-, it's

horrible, it's really-, I think that's a great pity. I think there should be more facilities for feeding, more places for mums to go to feed, because there must be a lot of mums who are out shopping and the baby suddenly wants feeding.

(Andrea:17:2:33)

I think they should have a mother and baby room or something that you can sit and feed, in the back of Mothercare or something, that you can sit and feed them and change them.

(Milly:33:2:26)

Oh dear, you should have seen the eyebrows raise of the doctor's receptionist when I said, 'Can I have somewhere to feed him?' Cos she's one of these old ones. She says, 'Well, if there's not many people in there for you to wait, can't you make him wait?' And I thought, 'Have you ever tried to make a hungry baby wait?'

(Edwina:7:2:22)

There were variations in where the women felt they could breastfeed and in front of whom. In some cases women found greater tolerance than they had expected, but they could also suddenly come across evidence of embarrassment where they had not expected it.

...initially I was embarrassed in front of my dad. When dad was around I'd go upstairs to the bedroom. Mum

said, 'Oh, for goodness sake, he doesn't mind, he's quite happy.' So I don't mind now.

(Andrea:17:2:29)

But later, from the same mother:

We've got this friend who's particularly way out. When I say way out, that's an awfully old-fashioned expression, but he was a real hippie type in his youth...He's settled down and got a family of his own now...And I really thought, gosh, now, he's the last person that would mind, and he did. I mean, he was so embarrassed, it was incredible...He made little comments about not having ever seen that part of my anatomy before...Yes, he blushed scarlet.

(Andrea:17:3:17-18)

The mothers could choose either to take steps to avoid the possibility of causing embarrassment, or to refuse to let other people's possible embarrassment bother them. Occasionally mothers expressed this latter sentiment, but in limited circumstances, e.g. in their own home, or in situations where they felt at home and were not in awe of the other people present. But overwhelmingly the mothers felt they had to avoid causing embarrassment, and they therefore had to make judgements about when and where they could do it.

The people that we were with last night we've actually been on holiday with, and I don't mind that. Another night when we were round at a friend's I did turn my back



because it was um-, one was an old friend but there was a very young couple, like one was twenty-one and the girl was in her teens, and I knew that they would be embarrassed, so I turned my back. I got a dining room chair, I just sat there with my back to them. And it was discreetly done, and they weren't aware, all they could hear was her sucking. That I didn't feel happy with I must admit...simply because I knew that they were embarrassed, and I knew that because I had been round at another friend's the previous afternoon, and they'd arrived to see her and they just didn't know where to look...

(Sheena:6:2:27)

...the only people who've been here really when I've been feeding are close friends or family who aren't embarrassed anyway...We've taken him to church the last two weeks and as soon as we've got there he's woken up so I spent my entire time in the vestry in glorious isolation feeding him. Cos I can't really do it in the middle of a church service.

(Nancy:9:2:28)

...We went to friends, and she was crying in the other room. I went in the other room and was feeding her. The girl that we were visiting said, 'Don't feel uncomfortable bringing her in.' That was mixed company...And there's

been another occasion where we had dinner at some people's house, and I just went upstairs and fed her upstairs because in that situation I think that they would have felt uncomfortable. I think I would have, too. It just, you know, depends on the situation, and what the people are like...It wasn't appropriate for me to disrobe in front of everyone. I think they would have thought it was crude.

(Roberta:46:2:23)

...It depends on who it is. No problem feeding in front of women, but some men would feel very uncomfortable. I wouldn't do it in front of the washing machine man<sup>5</sup>.

(Roberta:46:2:22)

Well, at the NCT things I've been to it's perfectly OK of course, and I've been to people's houses for coffee, friends of mine, and I've been OK then. The two Christenings I went to...I had to feed upstairs, because it was mainly-, was it the fathers? Father-in-laws<sup>6</sup> both times, of the babies who were being Christened. The mothers hadn't fed in front of them their own children, and suggested to me perhaps it would be better to go upstairs...

(Sheena:6:2:29)

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<sup>5</sup> Roberta's washing machine was being serviced at the time of the interview.

<sup>6</sup> Sheena is referring to the babies' grandfathers.

My in-laws feel very much the same. They won't stay in the room when I'm feeding.

(Interviewer: Did that surprise you?)

Ah, not with my in-laws but it did with my sister-in-law as she's only twenty. I expected a much more relaxed attitude to these things. I mean from somebody who'll sun-bathe topless on a Greek beach to not staying in the room when you're breastfeeding, I can't comprehend.

(Edwina:7:2:14)

So you can find yourself out in the shops or in public places and you're stuck. What do you do? As I say, I've fed her in the car in the car park, but I don't know what the reaction of the public would be if you suddenly sit down and start feeding...I don't know whether the police would come and say, you know, 'You can't do that here.' Move me on or something.

(Andrea:17:2:33-34)

We took him to a wedding when he was two weeks old, a wedding reception on a paddle steamer...which, as it turned out, was quite cramped. I couldn't really have fed him, but with a bottle it was all right. ...there were quite a few middle-aged relatives. They might have been embarrassed.

(Pamela:16:2:10)

The self-proclaimed feminist who, at the first interview, had said she wanted to challenge public attitudes, did in fact take steps to assert her right to breastfeed wherever she chose. In the quote which follows she is rewarded by receiving expressions of approval, but she also shows consciousness of the possibility of disapproval, which she shuts out by avoiding looking round, and she also has her husband with her for protection (although she is not totally sure of his approval for her behaviour).

And what I really like is when we're out and he cries for a feed and I don't have to hurry home. I can just feed him there. I think that's really nice. I feel very proud as well. I fed him in the town centre, and little old ladies come up and say, 'You're such a good mother.' They say, 'Oh, it is wonderful, don't see many people doing this nowadays.' And I sit there beaming away. It's really nice...because we were shopping in Sainsbury's and the queue was very long and he started to cry, and I just picked him up and put him on. I mean, I got my husband to position himself so I was screened from people while I got him fixed on, and I just stood with him feeding him, and I thought, 'Oh, this is so easy compared with what people who bottle-feed must go through.'...Melvin thinks I'm a bit brazen I think. Oh, I did in Argos as well. We were a long time in there, and that was the first half of the feed he had in there...what I tend to do is I tend to look at him a lot while he's feeding and so I don't notice whether people are

looking at me or not, until these old ladies come up...

(Interviewer: Do you think people do notice?)

I think they might do. I think they look, they're not sure because it does look as if you're just cuddling the baby, but your T-shirt's all rucked up. No, I think that people do look, but I've not had anybody staring a lot or anything like that...I haven't fed him on my own yet though, out in public. I mean Melvin's always been with me. So I am a bit more reluctant to do it on my own, cos I know Melvin would defend me if anyone said anything.

(Maureen:11:2:27-28)

But to most women, the most obvious and easiest-seeming solution was either to convert breastfeeding into bottle-feeding by expressing milk beforehand to be given in public by bottle, or to substitute a bottle of formula.

...we went out for lunch on Sunday, we went to a hotel, and so I expressed some milk, which took absolutely ages...it was because we were taking her, and if she woke up in the middle of the meal there was nowhere that I could take her to feed her...and if that was what she wanted we'd be stuck if we didn't have it in the bottle...Just fed her at the table with the bottle...she woke up just as the pudding was coming, so I ate mine quickly and then I could feed her while everybody else was having

theirs and their coffee.

(Gaynor:32:2:12-13)

That mothers would have bottle-feeding equipment to hand, sterile and ready for use, was ensured by their belief that their babies had to be given drinks of water or fruit juice. So even mothers who completely avoided using bottles for artificial feeding still felt obliged to maintain bottle-feeding equipment.

And this book says that breast milk should be enough and you shouldn't have to give them any water, whereas the midwife and doctor say that on a hot day you should give them water. Which means you've got to have the sterilising unit set up, you know, all that. So you don't really know, as far as water goes, whether to give it to her or not. You want to avoid having to have the hassle of sterilising, and you have to have it, I have to change it every day and keep a bottle every day in case she-, you know, you think you ought to give her water.

(Ruth:37:2:30-31)

All in all, even for mothers for whom breastfeeding was the sub-cultural norm, artificial feeding remained a safe, reliable alternative, a necessary stand-by, and the socially acceptable way of feeding a baby in public.

#### 10.2.2 Benefits to Baby

Although the mothers continued to believe in the superiority of breastfeeding as an ideal, their fears that in practice there were ways in which a mother's milk supply could be unreliable did not seem to be dispelled by their actual early experiences. In

comparison, artificial baby food was viewed as a standardized, measurable product, specially formulated to meet babies' needs and manufactured to high standards.

It has already been shown how the mothers' expectations that their babies should be satisfied for about four hours could lead to doubts about the adequacy of their milk. The mothers tried various remedies for fretfulness between feeds, including drinks of water or flavoured water, gripe water, nappy changing, holding or playing with the baby, rocking, bouncy chairs, pram rides, music or other noise, dummies, etc., but when a baby remained fretful the only remaining explanation was that it must be hungry. Instead of confidently responding by putting the baby to the breast, the mothers agonised over whether this was the appropriate response or whether they should supplement with formula. Even when mothers believed that feeding would stimulate their supply, they still felt that this would not be instant enough, and formula was needed in the mean time. For instance, Sheena was able eventually to establish full breastfeeding, but at the one-month interview:

I'm an ounce deficient. I'm having to top up her feed...Now I'm feeding her every three hours to build up my milk supply, and if I had done that whilst I was in hospital I might not have had this problem now.

(Sheena:6:2:8)

The natural process of producing and delivering milk through their own bodies seemed very vulnerable to disruption compared with the reliability of the manufactured product. Mothers therefore feared getting tired or tense, 'over-doing it', or falling ill, events which they could not fully control.

I have run out of milk once, or what appeared to be that

I'd run out of milk, and that very much upset me, cos I thought, 'Oh, this is the beginning of the end.' But it seems to have righted itself. I think it was just that I'd been on the go. I'd gone from one place to another, and fed him, and fed him twice within a very short period of time, and he sort of came off screaming each time and I thought he'd just got wind, and then I went out, and it was the first time I'd gone out, and I think I was conscious of the fact I was going out. I don't know whether I'd run out or whether I was tense and just hadn't relaxed enough...

(Gwen:44:2:9)

What I didn't find particularly useful is the things that I can't manage which is like telling you to have a rest in the afternoon or to drink plenty, because as life settled down I-, either he doesn't go to sleep long enough for me to rest in the sense of lying down, and I get anxious because they say your milk supply will diminish if you don't rest. And I sit here some evenings and say to Melvin, 'Oh, what if my milk's failing now?'

(Maureen:11:2:25)

Some mothers worried their babies' fretfulness from apparent colic might be due to their having inadvertently contaminated the milk with something unsuitable.

I had plenty of milk and I wasn't having any problems getting him fixed on, he seemed to be taking it. It was



just that he was crying so much apparently with wind. I kept worrying about what I was eating. I was: 'Er, was it that liquorice stick I had?' I ended up on one of the blandest diets I've ever had in my life, and I've gradually reintroduced vinegar and tomato ketchup.

(Maureen:11:2:22)

One vegetarian mother was advised to give vitamin drops, which she believed was because her own diet could not be relied on to produce milk with all the necessary vitamins, an assumption she did not question although she had never worried about whether her diet was adequate to sustain her own health.

But some mothers believed that breast milk was deficient in vitamins anyway, especially once the baby was a few weeks old. Compensatory measures had to be taken which did not apply to artificially fed babies since formula was seen as having all necessary nutrients added in the manufacturing process.

I was thinking about fruit juices. I was looking at it today, in fact, the Cow & Gate fruit juices, and they say that you can give those at four weeks, because they do say with breastfeeding you're vitamin C deficient.

(Interviewer: Who says that, then?)

The books do...I tend to think because she is on partly powdered milk, she's probably getting as much vitamins as she needs from that as well, perhaps.

(Sheena:6:2:36-37)

... I gather breast milk doesn't contain all the vitamins

needed...The GP said, actually...said it was a bit-, breast milk was a bit deficient in vitamin-, not absent but deficient in vitamin D.

(Irene:3:2:31)

But reading, as I say, in the book it sort of said if they're bottle-fed, then the feed's got vitamins in anyway, and usually you needn't start giving additional vitamins till they're about four months...If you're breastfeeding, then yes, they say give vitamins because the breast milk hasn't got all the vitamins that they need after the month, but a bottle, because it's a made-up feed, has got the additional bits and pieces.

(Stella:29:2:23)

Such deficiencies were mentioned by a small minority of the mothers, and yet they all said they had learned of them from expert sources.

It was very common for mothers to believe that breastfed babies needed drinks of water. Some viewed this as only necessary when the baby was fretful in case thirst was the problem rather than hunger, or to help bring up wind, but some saw it as a necessary daily addition. Professional advice to give water to babies began in the 1970s and sprang from the observation of problems with bottle-fed babies such as 'hypernatraemic dehydration' because of 'high solute loads' in formula (Palmer, 1988, p.272), but the advice was given to breastfeeding mothers also. Since then research has shown that breast milk provides all the water necessary to quench thirst, and even adjusts in hot weather to provide a greater ratio of water (Goldberg & Adams, 1983). This,

then, is an example of one way in which mothers could be encouraged to have greater confidence in breastfeeding than artificial foods, but the mothers were not aware of it. Instead it was common for breastfeeding mothers to feel anxious when their babies rejected the offered water. Some mothers just gave up offering it, and some tried flavouring the water with substances such as sugar, honey, fruit juices, fennel, etc.

...I've tried giving her water, and she doesn't want water in the bottle. She doesn't seem to want it, so the health visitor said, 'Well, try putting a little bit of orange juice in there.' So I've tried. I succeeded one day. She drank an ounce, but there again screaming her head off. She didn't want to know. She just didn't want to know. So to sort of calm her down I put her to the breast and she was as silent as can be. She was. Silent as can be. I thought, 'Good God!'

(Interviewer: Why did you want to give her water?)

They say you've got to give babies water because they sweat and that, and they do get thirsty, so this is what they suggest.

(Michelina:22:2:6)

Altogether then, despite the general belief in the superiority of breastfeeding, there were a number of ways in which mothers could believe their breast milk to be deficient. The vulnerability of their own bodies could make formula seem more reliable, but even when breastfeeding was working as it should there were beliefs about inherent limitations of breast milk.

### 10.2.3 Benefits to Mother

As has been shown, the early days at home with the new baby were a chaotic, anxious time for the new mothers, and trying to breastfeed involved particular problems and anxieties. By the one month interview things had become somewhat more settled, and, although mothers still had their worries and difficulties, they were beginning to appreciate certain advantages and personal satisfactions from breastfeeding. But, in the main, the early period was a struggle to overcome, or find ways of managing, the difficulties involved in breastfeeding.

Many women came home from hospital still experiencing painful physical problems such as sore nipples, engorgement, breast infections and painful let-down reflex. Although these had cleared by the one-month interview, for many women they had amounted to a physical endurance test. For instance, Vanessa had cracked nipples, but kept going with the aid of a shield:

...as I say, for the first three weeks it was painful, and I honestly didn't enjoy it, and I thought, 'How do people enjoy breastfeeding?'...I kept hoping it would get better, because they said to me all you should feel was a gentle tugging action, where I was actually feeling, well, pain, that's all it was, and I thought, 'Uh, well, this can't be right. Perhaps it'll improve,' and just kept going...At one stage I did consider-, if it didn't get better by-, I let myself have about five days, if it didn't get better by that stage I was going to ring up Marilyn (NCT breastfeeding counsellor) and ask if I could use the electric pump, see if

I could borrow that. But fortunately it just improved at the right time.

(brackets added)

(Vanessa:12:2:91)

It has been shown earlier in this chapter how difficult it was for mothers to build up confidence in their breastfeeding abilities, and how much easier it was to trust the measurable formula milk. That they often found feeding by bottle easier because of lack of skill in positioning the baby and getting it latched on has also been mentioned.

By the one month interview many of these problems had been overcome, and mothers were gaining confidence, although they still had their uncertainties. But by this time they were more and more trying to 'get back to normal' - assimilating baby-care into their lives rather than being totally dominated by it. But here again breastfeeding seemed to have a number of draw-backs. Many women said they thought it more time-consuming than bottle-feeding: feeds took longer and were more frequent. Also, it tied the mother to the baby more than bottle-feeding because feeding could not be passed over to anyone else while the mother did something else or went out without the baby. On the other hand, the work of sterilising bottle-feeding equipment and preparing feeds (which could be done in advance) could be incorporated into housework routines, and also shared by the father. The fact that mothers had other duties to fit in also sometimes made the advice on how to build up one's supply (feeding often and resting) difficult to follow. The mothers also frequently thought that breastfeeding contributed to their tiredness - although here the emphasis was not so much on it draining their own bodies, as on factors such as having to spend more time doing it, having more disturbances at night and not being able to pass it over to someone else. Also, initial awkwardness in

positioning meant that some women found breastfeeding physically hard work.

It has been shown how mothers used bottle-feeding, either for expressed breast milk or formula, to get over the problem of public embarrassment. But this did not always turn out to be an easy solution. For one thing, some mothers found expressing milk more difficult or repellent than they had expected and therefore had to use formula (although there were also mothers who had felt repelled by the idea of expressing before birth but who took it in their stride when required after birth). But, more importantly, once babies had grown accustomed to the breast they usually rejected a bottle and teat - whether the contents were formula or expressed breast milk.

...I went to a wedding last Saturday, and I left the little one with my mother-in-law, and I made two bottles up for her...my mother-in-law said that she woke up at half-past six screaming her head off cos she wanted to be fed. So she comes in here, my mother, warms up the bottle and everything, and she said, 'Honestly,' she said, 'trying to give her the bottle,' she says, 'it was hell.' She just didn't want to know. She was spitting it out, she was getting really nervous, screaming her head off, and all she took was three ounces from the bottle, and my mother said she literally fell asleep with the bottle in her mouth.

(Michelina:22:2:5)

Breastfeeding could also involve a certain amount of leaking and 'mess'.

...if I do go out in the evening, and say if I was going to miss two feeds with him, by the time the second feed

comes, they start leaking, and if I forget to put pads in or something, panic. Oh, my god. I've got stains all down the front of my shirt or something. I think, 'Oh no, how embarrassing.'

(Milly:33:2:31)

As to the promise of getting one's figure back more quickly, not one mother referred to this at the one month interview, whereas some did mention feeling top-heavy, and the restrictions of having to wear special bras and front opening clothes.

Obviously I have to wear things that open down the front or lift up, and most of my dresses and things actually are not really suitable. That's a bit of a nuisance. I look forward, as I looked forward to wearing non-preggy clothes, I'm looking forward to wearing non-feeding clothes...

(Andrea:17:2:30)

By the one month interview, most of the women had experience of feeding both by breast and bottle. When asked whether they thought breast or bottle-feeding was easier, the mothers were generally ambivalent. Some mothers who were still breastfeeding argued strongly that they still thought breastfeeding easier but only once initial problems had been overcome. But it was common for women of all social classes not to give clear answers to this question.

I should think bottle-. Well, I don't know. I would have thought breastfeeding is easier if you don't have all the other problems. If you don't have problems like I have

had with breastfeeding, cos I mean bottle-feeding is just sterilizing and giving it to them and winding them. That's it, and at least you know how much you've given them...

(Pauline:34:2:21)

Bottle-feeding isn't as difficult as I thought it would be. The sterilizing, it's a lot easier than it used to be. It is a fag. I mean it's much easier just to pick him up and put him on the breast, but if you were worried about him, like I've been worried about him and the fact that he won't take anything, it is quite reassuring to actually see milk going into him...I think breastfeeding is easier, but it's more draining. I don't know whether it actually makes you tired, but the fact that you are on call, and you can't give it to anybody else to do. Sort of say, 'Oh look, would you feed him this time?' which you would be able to with a bottle...

(Gwen:44:2:17-18)

Bottle-feeding mothers were happy to cite all the advantages of their method, including mothers who had tried to breastfeed even if they had been disappointed at having to give it up. One mother who had chosen to bottle-feed found cleaning the bottles more of a chore than expected, but she felt all the other advantages still outweighed this. Only one woman who had chosen to bottle-feed said she felt some regrets after returning home from hospital, at not having tried to breastfeed - because, after reading some magazine articles on the subject, she felt guilty and 'wicked'



(Trudie:45:2:10), and because she worried about the risk of inadvertently contaminating formula during preparation.

However, despite all the problems and draw-backs involved, at the one month interview those mothers still breastfeeding were able to talk also of gaining a certain amount of pleasure and satisfaction from it.

I think it's quite nice, the physical contact, sort of holding her and-, and also, I don't know why, but she looks much sweeter when she's feeding, the attitude of her head or something. I suppose the knowledge that you're actually sustaining the baby yourself is quite nice when you think about it, although I don't often think about it, I don't think.

(Tabitha:4:2:34-35)

Once mothers were relaxed, it was possible for them to find breastfeeding restful.

In a way it's quite a pleasurable experience, and I think it makes you fairly close to the baby. It's quite nice, it sort of makes you sit down. They all say, 'Well, sit down and put your feet up when you get home.' There's so much to do that you tend not to do it, but you've got to sit down and feed so that's quite nice. It's restful.

(Hilary:1:2:9)

Also, the fact that only the mother can breastfeed can be a source of satisfaction.

...it's something nobody else can do. You know, it's

special for us. It's just something that we can do together.

(Gaynor:32:2:20)

Well, it's a very peaceful, close thing to do I think, and I get great satisfaction that he's growing from something that I'm producing, cos he's not taking anything else at all apart from the odd squirt of water if one can get it down him.

(Valerie:13:2:17)

It should be noted, though, on the point of feeling close to the baby and bonding, bottle-feeding mothers felt strongly that it made no difference to them, and breastfeeding mothers who had temporarily resorted to bottle-feeding agreed that it had made no difference to their feelings for their baby even if the physical contact was not so close.

The breastfeeding mothers who resorted to supplementing with formula because they feared milk insufficiency tried hard to re-establish full breastfeeding, and a number of them were successful. These mothers felt that combining breast and bottle-feeding gave them the worst of both worlds - their breastfeeding was time-consuming, whilst they still had the work of preparing formula feeds and sterilising the equipment. Nevertheless, one mother who came to the conclusion that she never would be able to satisfy her baby completely herself decided to carry on with breastfeeding in combination with bottle-feeding.

...I have rather mixed feelings about it. I mean it is a bit of a bore. I would much prefer it if I could give up using the bottle altogether, and I'm not sure how long I'm prepared to go on doing both because it is quite a lot of

trouble and it means that feeding takes quite a long time...But on the other hand, I'm very reluctant to stop breastfeeding cos I think the satisfactions on both sides are quite considerable.

(Interviewer: Do you enjoy it?)

Yes, and I know she enjoys it...

(combination fed for three months)

(Sarah:2:2:32)

But the rest of the combination feeders felt they had the best of both worlds - having the pleasures and benefits of breastfeeding for themselves and their babies, but able to shift to bottle-feeding when it became burdensome, and having a baby accustomed to taking a bottle when out or with a baby-sitter. But these combination feeders did not feel that bottle-feeding had been forced on them by breastfeeding inadequacies, but that it was more a matter of their choice.

Hilary, for instance, was following her sister's example in accustoming her baby to one bottle a day so that she had an alternative method of feeding for public places or for baby-sitters. Connie, who had worked hard and endured a great deal of discomfort while in hospital to overcome difficulties in establishing breastfeeding, introduced the bottle about a week after returning home at the point where she felt breastfeeding had become onerous.

...it was on day twelve that it got to the stage where she was feeding very, very slowly. She would feed for ten minutes, then she would go to sleep for half-an-hour...And then she'd be crying again, so I had to feed her for another

ten minutes. That's all very well during the day, but, you know, in the middle of the night, don't really want that to happen...and it means that you're sitting around with your bosoms hanging out, you know, for three hours practically, and you can't do anything else...and I was actually starting to hate her at that stage because I was still in quite a lot of pain...And it was on the twelfth day that I thought, 'Right, that's it, you're going to have to have the bottle,' because I just couldn't stand her sucking any more...And from then on I started giving her a bottle-feed once a day. Not any particular time...Just when I couldn't stand being sucked at any more...partly to give me a rest from her sucking, and partly cos, as you know, I want to go back to work, and there's going to be a time when she's going to need to have the bottle...and so she would have to get used to it...But she took it really well...It was only one feed a day. But then actually I quite enjoyed giving her the bottle, you see, because obviously she will take it quicker, and I was much more comfortable, and it was more convenient. There were times when I had to go to the dentist and things like that. And so then I started giving her alternate bottle-feeds and breastfeeds, and that's what I'm doing now...If I feel like feeding her by the breast, then I do, and if I can't bear it and I want to give

her a bottle-feed, then I do, and she takes both equally  
 well...

(combination fed for four months)

(Connie:23:2:16,17,18)

Clearly, the rewards for the mothers were sufficient for many to want to carry on breastfeeding. But there were also many disincentives, even after the initial problems had been overcome. Mothers had to assimilate feeding their babies into their other activities, and in many ways formula feeding could make this easier.

### 10.3 CONCLUSION

The return from hospital marked the taking over by the mothers of the responsibility for everyday care of their babies. The new mothers' lack of knowledge and experience meant confusion and anxiety, and breastfeeding mothers were particularly susceptible in that they were subject to so much conflicting advice and were trying to put into practice conflicting ideas. Trying to reconcile ideas from the medical model and the natural ideal meant that they lacked a coherent view which would make sense of their experience, and consequently it was difficult for them to have confidence in their breastfeeding abilities.

As things began to settle down somewhat after the confusion and chaos of the first few days, mothers came up against the special problems involved in trying to assimilate breastfeeding into their everyday lives, because of the social unacceptability of breastfeeding in public, and the disruption of other routines caused by mothers being tied up with feeding for long periods.

Keeping going with breastfeeding took determination and persistence, without immediate rewards. But by the one-month interview the mothers were beginning to gain

confidence and could talk about the pleasures they gained from breastfeeding. These were mainly emotional: the close relationship with the baby, pride in knowing they were doing their best for their baby, and the satisfaction of seeing their babies sustained through their unique efforts. But there were some practical rewards, too. When mothers felt confident they found it brought restful and peaceful intervals in an otherwise busy day. Also, there was the advantage of not having to prepare feeds or take equipment around with them.

When it came to keeping going with breastfeeding during the uncertainties of the early period at home, middle-class mothers were again at an advantage over the working-class mothers. Their relative lack of access to the knowledge of experienced mothers compared with working class mothers was a disadvantage as far as general baby-care was concerned, but their independence from these lay advisers was usually an advantage when it came to breastfeeding as they could more easily break the hold of conflicting medical model type ideas about feeding routines when faced with the reality of their babies' demands. Breastfeeding being more of a subcultural norm for middle-class women meant that they had higher expectations that it was possible to overcome difficulties and succeed at breastfeeding, and also meant that it could be more easily assimilated into their everyday lives. Also, in their relationships with their husbands they seemed more confident about asserting the priority of their own needs as breastfeeding mothers over having to care for their husbands.

However, the uncertainties and anomalies they came up against, combined with their general uncertainties about baby-care, against the background in the very early days of physical discomfort and debility, all combined to hinder the experience of the transition to independent motherhood being one of achievement. The natural ideal could

be seen as a possible contributing ideological factor here, even for those mothers who continued breastfeeding because of the compromises which had to be made with bottle-feeding

**CHAPTER 11: A RELATIVE CALM AND THE BEGINNINGS OF WEANING**

After the trauma of the first few weeks after returning home from hospital, the mothers gradually gained more sense of order to their lives, although the unexpected (e.g. slowing down in baby's weight gain) could still cause anxiety. The early breastfeeding problems such as positioning, sore nipples, breast infections and fear of milk insufficiency were overcome, and new occurrences of such problems were rare and did not lead to the abandonment of breastfeeding, although formula was usually resorted to in dealing with them.

Thirty two mothers (including four combination feeders) were still breastfeeding after the age of three weeks, and there were no more cases of mothers abandoning breastfeeding until the age of 11 weeks. In the interim mothers coped with breastfeeding and with the problems of social embarrassment with varying degrees of dependence on formula supplements, but they were all still sufficiently motivated to maintain their breastfeeding. However, as the babies grew bigger the mothers' perceptions of their needs and the value of breast milk changed. From nine weeks onwards mothers began introducing 'solids' to their babies. This was the beginning of 'weaning', and so the stopping of breastfeeding after eleven weeks can be seen as part of the early weaning process, even when it preceded the introduction of solids since it was done in the context of the women's changing perceptions of the baby's needs.

Weaning is here defined as the transition from a milk-only diet (breast milk or formula) delivered by breast or bottle, to a diet consisting of a variety of foods delivered by spoon and cup (including training cups with lid and spout). Weaning foods are typically referred to as 'solids' despite having the consistency of thick liquids. Earlier



this century this was seen as a fairly short process - not started until the baby was at least six months and completed within a few weeks. As the recommended age for introducing solids became earlier, the process became seen as much longer, spanning months. Today the official recommendation is that 'the majority of infants should be offered a mixed diet not later than the age of six months, and that very few will require solid foods before the age of three months.' (DHSS, rev. 1983, p.37) In this study most of the mothers began introducing solids between three and a half and four and a half months, the earliest being nine weeks, the latest 23 weeks (see career charts, Appendix 6). Very seldom was this done without the health visitor's approval. There was slight variation in the expert advice the mothers in the study received as to when they should start giving solids (from health visitors, literature and packet instructions), mainly as to whether it should be after three months or at four months.

### 11.1 SOURCES OF INFORMATION AND SUPPORT

During these weeks of growing confidence the mothers' dependence on expert advice and support lessened. After discharge from the community midwife's care, the only professional support that came directly into the mothers' homes was the health visitor, but after the first week or two these visits became infrequent.

However, all the mothers (except Diana who was being treated for cancer and who continued having frequent health visitor's visits at home) attended the clinics. At first this was frequent - weekly or fortnightly - but by the five month interview this had nearly always dwindled to one in a few weeks. At first the baby's weight gain was a major source of reassurance to the mothers, and was an important motivation for attending the clinic. Also, most felt a certain reassurance that there was a health visitor they could consult, and at first most mothers did make a point of having a chat with her.

However, as time went on mothers either felt less need for reassurance or ceased to see weighing and the health visitor as sources of reassurance (see below, 11.2.1), although at about the time of weaning they wanted information about this.

Another source of expert advice which the mothers reported making less use of as the weeks went by was literature, although, again, when weaning began they consulted leaflets and books about this. Nearly all of them received a Health Education Council leaflet through the clinic or from their health visitor on the subject, plus various manufacturers' leaflets which the mothers found equally helpful. Another source of information mentioned was the instructions printed on the packaging of manufactured weaning foods.

Seven women said they had attended some sort of NHS post-natal class. One said it was another six-week course of classes which her Health Centre was putting on as an experiment, at which the mothers practised post-natal exercises and heard talks on such matters as immunisation, teething and playing given by a midwife or health visitor, and also on weaning given by a representative from a weaning food company. The other mothers referred to these classes more as post-natal get-togethers about once a month, although they all seem to have included instruction on weaning either via a company representative or a video made by a weaning food company. But the majority of mothers seem not to have been offered any sort of post-natal class organised by the NHS.

Consultation of NCT breastfeeding counsellors ceased after the first few weeks. The NCT did not organise post-natal classes, and attendance by the mothers of occasional one-off NCT talks or discussions on various aspects of motherhood was not high.

As the women were becoming more independent of expert sources of advice and support, they were also building up their own lay peer-group support networks. This did not apply so much to some working-class mothers who already had close relationships with experienced mothers: sisters, friends, etc. as well as the older generation of their own mothers. But most of the mothers had begun their motherhood careers relatively isolated in their own homes, and as the weeks went by and they were able to venture forth to take part in wider social activity they were able to build up relationships with mothers outside their own immediate family circle. They particularly valued this contact with other mothers who were 'in the same boat', i.e. with babies of similar age currently experiencing the same concerns.

All the NCT mothers had invitations to post-natal class reunions which they all attended. Thereafter they maintained links with former class-mates, both on an individual basis and through organising their own regular coffee-morning reunions. These were more popular than the NCT's post-natal support group meetings which the women often felt were dominated by mothers of toddlers with different concerns.

Non-NCT mothers also built up networks of peer group support. Links with ante-natal class-mates were frequently maintained through reunions, bumping into each other again at clinics, or through individual contact. New friends were also made at the clinic, although some working-class mothers complained of the lack of opportunity for getting to know other mothers because there was nothing about the way the clinics were run to make them into social occasions (e.g. no coffee served, and nothing to encourage mothers to sit and chat). One mother said that the mothers she had met in hospital had organised their own reunion coffee-mornings, and one or two other women said that they had helped form their own neighbourhood groups either through their own initiative in

calling on other mothers to introduce themselves or though being approached in this way. Mothers also took opportunities to form individual alliances with other neighbouring mothers. A couple of women also attended mother-and-under-fives type sessions held in local halls (at least one being under the auspices of the NCT but open to non-members).

So, whereas the mothers had struggled with the early problems of breastfeeding isolated in their own homes, when it came to later stages of development including the beginning of weaning there was a great deal of sharing information and experiences with other mothers.

...if you find like Steve's doing something or not doing something, you tend to find that-, you generally chat about things and find, 'Oh yes, well, so-and-so was doing that and I did this or that.' I find that very helpful, because we're all first-time mums, but once you know somebody else has had problems or is going through the same thing, you don't feel quite so isolated.

(Cynthia:14:3:9)

...it's nice to swap bits of information with each other, like one person might find one product better for teething than another, and the only way you're going to find out is by talking to other people about it, and, as I say, if they're all at the same stages, which they are, then it's quite good. We compare nappies and things, things that I never

thought I'd talk about.

(Sheena:6:3:17)

...mainly I got advice from other women actually because although I did ask the health visitors when I used to take him to the clinic, they used to say things like, 'Well, use your common sense,' and really I wanted someone to say, 'Here's a diet sheet. Follow this.' So I asked around people who'd had babies before and sort of culled information like that...

(Maureen:11:3:1)

...I've got about four or five friends who are in my NCT group, and we sort of pool all the health visitors' information, and sort of then decide what we're going to do out of that.

(Gwen:44:3:8)

## 11.2 PROBLEMS AND CONFLICTING ADVICE

Evidence of conflict in the mothers' ideas and in expert advice was still discernible during this period in the mothers' anxieties and decision making.

### 11.2.1 Baby's Weight Gain

At first having the baby weighed was a major source of reassurance to breastfeeding mothers, and was an important motivation for attending the clinic. A regular gain in weight every week was taken as a sign that all was well. However, many of the mothers reported that their babies' weight gain slowed down or became static for a while at some point between two and three months, or even that there had

been a slight loss of weight. For breastfeeding mothers this raised doubts about the adequacy of their milk. It was rare for mothers to take a longer term view of the baby's growth, and they seldom seemed to derive from their health visitors the idea that babies might have growth patterns other than regular weekly gains. Consequently when their health visitors seemed unconcerned and told them not to worry, they found it difficult to feel reassured and still wanted an explanation.

Sometimes the mothers gained reassurance from subsequent weighings which were judged as satisfactory, and found their own explanations for the temporary fluctuation such as the baby's having a cold, hot weather depressing the baby's appetite, faulty scales or readings, the baby wearing lighter clothes, etc. But the experience also led them to revise their perceptions of weighing as a reliable, or useful measure of well-being.

...But I don't think he had lost, you know. I think the loss in weight was the less clothes, and he'd probably only put on an ounce or so by her weighing, but it didn't unduly-. Well, it worried me at the time. I thought, 'Oh my goodness, he's lost weight!'...I mean I was worried, although at times I think, 'Gosh, these stupid weighing scales. Just take one look at him and he's healthy. Why do I let myself get worried by weighing scales?' But nobody else seemed particularly bothered, and only one week's only one week...

(Audrey:10:3:8-9)

I think partly the fault was the clinic weighed her wrong

one week and then it made a complete nonsense the next week...I mean, looking at the overall weight gain she's done very well, she's just on the slower side. It is hard not to be too obsessed with the weight aspect of it, which is silly really because I think I'd be even more worried if she was putting on a lot of weight...I think it's a mistake to go every week and I don't do that any more.

(Irene:3:3:8)

But quite often their health visitors seemed to confirm that the fluctuation was a cause for concern by discussing with mothers what should be done. Two mothers, Nancy and Tabitha, began giving formula supplements as a result. Tabitha dropped the supplement after about a week because her baby was refusing it, and her fears were allayed by subsequent weighings which seemed satisfactory. But Nancy continued as a combination feeder (one feed per day) until well after solids had been introduced. In some other cases where the baby was close to or at three months the solution was found in introducing solids.

A less common worry was that the baby was gaining too much weight, but when it occurred mothers were at a loss to know what to do since they anticipated that cutting down on feeding would result in a fretful baby. This applied to both breast and bottle-feeding mothers, but was particularly bewildering to breastfeeding mothers because one of the arguments put forward by expert opinion in favour of breastfeeding was that mother's milk was the perfect food and would not make the baby too fat. Also, one breastfeeding mother feared that cutting down would have a detrimental effect on her milk production. When the evidence of measurable weight gains in excess of the limits

laid down in medical lore competed with the mother's belief in the 'natural' rightness of her own breast milk for her baby, medical advice did not encourage the mother to see the fault in the growth charts even when the advice was meant to be reassuring.

Well, they've got all these charts now, but they say-, obviously the average British baby is such and such at such and such age. I think, 'Well, oh dear. She's about three pounds over.'...

(Interviewer: What did the doctor say?...)

He said there's nothing you can do. You can't just stop breastfeeding or anything, or cut down. Obviously I've got rich milk, so. 'Gold top,' he said. They have tried different methods before with other women. You know, sort of cutting it down. It doesn't work. It only makes the baby irritable. So. Eventually they work it off anyway, when they start crawling.

(Pauline:34:3:1-2)

...the health visitor started telling me off, not my own health visitor but one at the clinic, because she's got so much weight.

(Interviewer: How do you mean telling you off?)

You know, 'She's very big for her age,' and 'They're more liable to get colds,' and whatever. I thought you couldn't over-feed a breastfed baby, but they seem to think you can, so. I was giving her, during the summer, a milk



feed, whereas she should have had water. But she wouldn't take it at first, and then one afternoon I put a little bit of fruit juice in, and she gulped down four ounces, but that was the only time she ever did have much water.

(Ruth:37:3:3)

Once weaning had commenced worries about weight no longer implicated the mother's breastfeeding since they were then advised to increase or decrease the amount of weaning food being given.

### 11.2.2 Advice on Weaning

Expert sources had encouraged the women to breastfeed for the first few weeks or months, but as the babies reached the early weaning stage there were no suggestions of continuing benefits. Breastfeeding was not discouraged and most women felt it was a continuing option, except that there was evidence that some women had the impression from advertisements for follow-on milks that this was not just a better milk for the second half of baby's first year than either cow's milk or new-born baby formula, but that it was also more suitable than breast milk.

Altogether, as time went by, the amount of active encouragement for breastfeeding received by the mothers from their medical advisers lessened. Having the baby weighed reassured breastfeeding mothers only so long as weight gains fell within pre-defined limits. If not, medical advice did little to prevent mothers blaming their milk. Also, as the babies approached weaning there was none of the emphasis that strong advocates of the natural ideal (e.g. La Leche League) put on the continuing benefits of breastfeeding for babies, and mothers became vulnerable to manufacturers'

implied suggestions that babies would actually benefit more from specially formulated substitutes.

### 11.3 CHANGING PERCEPTIONS AND EXPECTATIONS

I shall now examine the women's experiences during this period using the classification drawn up from their expectations at the pre-natal interview.

#### 11.3.1 Breastfeeding as a Norm

As the babies grew older the mothers saw them as less in need of the special qualities of breast milk, and felt less and less that they were expected to breastfeed. On the whole this happened sooner with the working-class women, a few of whom had made the explicit assumption in the early interviews that breastfeeding did not normally extend beyond two to three months anyway. Middle-class mothers had been more vague: at the one-month interview they had found it difficult to look ahead, but had vague assumptions that a baby of weaning age no longer needed to be breastfed and that this would therefore herald the end of breastfeeding. However they tended not to share the working-class assumption that bottle-feeding was a stage in feeding after a few weeks of breastfeeding. Nevertheless as the babies grew older all the breastfeeding mothers found themselves increasingly outnumbered by bottle-feeders amongst their peers, even in the NCT groups. But working-class mothers were more likely to feel they had deviated from what was expected.

A friend of mine, whose baby's a week older, we were saying the other day that people say, 'Oh, how old's your baby?' and you say, 'Four months,' or whatever, they say, 'Oh, you're still breastfeeding?' You know, as if you just breastfeed them for a couple of weeks and that's it. Like

she was saying people tend to make her feel rather guilty  
that she is still breastfeeding...

(Social Class III)

(Gaynor:32:3:5-6)

At the five-month interview the weaning process had begun and mothers were now anticipating more clearly how long they would go on breastfeeding for. That bottle-feeding is culturally established as a stage that even breastfed babies go through was evidenced by the way continuing breastfeeders made conscious decisions, with explicit justifications, to avoid this stage by carrying on breastfeeding until the baby was fully established on solid foods and cup.

But hopefully I can go on breastfeeding until she's six months when I can put her-. I mean obviously if I'm still feeding her then, fair enough, but I don't want to have to go on to powdered milk. I'd rather go straight on to cow's milk...

(Gaynor:32:3:6)

### 11.3.2 Benefits for Baby

As has been said, as the babies grew older they were seen to be less in need of the special qualities of breastmilk, especially as they entered the weaning period when other foods were being introduced. There was therefore less incentive for mothers to make efforts to overcome problems or to carry on if they found breastfeeding onerous. In particular, mothers who feared milk insufficiency in the early days or weeks and who had been willing to go to considerable lengths to stimulate their supply, and to carry on as combination feeders if their efforts were not totally successful, often now came to feel

that such efforts were no longer necessary.

I tried that (increasing milk supply), and then I just gave up. It was too much trouble. And I figured that she'd gotten the most benefits from breast milk, which was really the first month, so I was ready to call it quits then anyway.

(brackets added)

(Roberta:46:3:3)

I went on doing that (combination feeding) for three months, and when she got to three months I found that I really wasn't producing enough milk and it was all taking too much time, and it didn't seem quite so necessary to breastfeed her then, so I stopped.

(brackets added)

(Sarah:2:3:1)

But more than this, as the babies grew older mothers were less likely to see breast milk as adequate for bigger babies with bigger appetites. The period just before the introduction of solids can be seen as a critical time in that the mother will see the baby as needing more than just breast milk but not quite ready to start solids. Formula was often seen as more satisfying, more of a 'real' food for a bigger baby. The amount of formula supplement offered therefore increased and breastfeeding was superseded.

I think I stopped breastfeeding, well, a maximum three months, but really from two months to three months or so.

I was having less, breastfeeding less, so one makes the

other, and I think she just went off it...She just wanted the real thing, the bottle.

(Françoise:43:3:1)

She didn't really like mother's milk any longer. She'd had a taste of the richer stuff.

(Roberta:46:3:4)

At the five month interview the mothers no longer justified breastfeeding with reference to the health benefits it conferred on the baby, although there were still references to psychological benefits.

Specially that morning and evening feed. I think it's nice for them to, you know-. It's comforting to wake up or go to sleep at the breast.

(Gaynor:32:3:6-7)

### 11.3.3 Benefits to Mother

As the mothers gained confidence they increasingly gained a great deal of personal satisfaction from feeling that they were sustaining their babies in the best possible way from their own bodies. But as the babies grew older and the mothers came to believe less and less that they needed the special qualities of breast milk, the less they felt they needed to put up with the personal disadvantages of breastfeeding if these seemed to outweigh the advantages. For many mothers giving up breastfeeding was an important step in 'getting back to normal'.

...when I was breast and bottle-feeding her it took an awful lot of time, and I didn't mind so much then cos I was quite happy to sit around a lot of the time. In fact I

felt like sitting around cos I was feeling a little bit tired, and so that worked, but after a bit it didn't really work because I didn't find really I got the time to do this because I was just doing more. I think that's one of the reasons why I stopped.

(Sarah:2:3:2)

If someone comes to the door, you can just chuck the bottle down and go to the door and that's it, whereas if you're doing it yourself, you've got to tidy yourself up, and, you know. It's so much easier, that side of it, bottle than breastfeeding.

(Donna:47:3:16)

...she's nearly five months and I think I've done it long enough really. Just so that I can go out more and things like that. And cos I'm fed up with wearing breast pads and everything, to be honest, as well. It just gets a bore after a while. You know, the type of bra you have to wear and things. It gets on your nerves after a while. And sitting there half undressed in the morning freezing cold. (laughs) You know, freezing. To me now it'd be easier, for a bottle, because really by the time they're about six months they don't have so much milk anyway. They're more or less, you know, they can start having it from a cup and that. So really there's only about a month

that I'd have to (bottle-feed).

(brackets added)

(Fern:39:3:4)

However, changing to bottle-feeding was not always easy. As has been seen, the fear some women expressed at the first interview that a breastfed baby might refuse the bottle was realised by a number of the mothers whose babies were not accustomed to bottle-feeding. This caused considerable anxiety to two mothers (Andrea and Anneka) who were returning to work at six months and who had to have their babies accustomed to an alternative method of feeding in order to be able to leave them with minders. In the event they both found the solution in going straight on to training cups, and their babies were therefore fully weaned soon after six months. This was not a problem encountered by combination feeders since for them it was *simply a matter of gradually increasing the* amount of bottle-feeding in relation to breast, thus effecting a smooth transition. In fact, two combination feeders (Connie and Françoise) who had intended to have their babies off the breast by the time they went back to work at about two and a half months, in practice continued breastfeeding slightly longer than anticipated since they both continued giving early morning and evening breastfeeds for a while after they had returned to work.

However, there were sufficient advantages and personal satisfactions for some of the mothers to feel at least some regrets at no longer breastfeeding.

...I don't think I'd do it that way again...I think I'd just put up with being tired...I suppose I could have reversed it, but I thought, 'Oh no, I've burnt my boats now.' But I did miss breastfeeding, and of course there's an awful lot

of pallarver with all this sterilising and making up feeds, and it's more expensive, and I think in future I would try and breastfeed for longer if I could.

(Irene:3:3:5)

No, at night is when I miss it really, cos it was really nice just to get up in the middle of the night. There was nobody else around, just me and him. That's the only time I miss it...I make his bottle before I go to bed. I wrap it up in a blanket and everything to keep it warm so that when he wakes up-. No, I suppose it's about the same for being easy, but I prefer to have breastfed him at night, because when I first weaned him on to the bottle, I was just not breastfeeding during the day at all and just breastfeeding at night for ages, and I was really happy with that. And then he wasn't. He was still hungry in the middle of the night, so I just put him on to a bottle at night as well.

(Milly:33:3:3)

A number of women found they were in no hurry to stop breastfeeding. They now felt confident doing it, and had found ways of managing the draw-backs. For them the advantages outweighed the disadvantages. This does not mean that they wanted to carry on indefinitely (one year was the upper limit), but to avoid having to revert to bottle-feeding as an intermediate step. Instead they wanted to carry on until the baby was completely weaned on to cup and spoon, and was old enough (at least six months)



to have the same cow's milk that adults drink.

I think I'd like to carry on till about a year, but I think he will have outgrown me by then because he's taking solids so well that, apart from the night feed which he will cling to I've a feeling, and perhaps the early morning feed, I think it'll be quite easy to wean him off the main meal feed.

(Interviewer: Any particular reason for wanting to go on to a year?)

Um, well, for a start I didn't want to go to sterilising bottles and things, so if he can't take it from a cup I'd rather breastfeed. So that's one reason. Well, I suppose it's still better for them, although probably marginal now. Not like it was at the beginning. What else? It's convenient. If you're out and you get stranded or whatever you can always breastfeed.

(Marcia:35:3:11)

Many women described how they enjoyed breastfeeding: that it could bring peaceful, restful interludes and a unique relationship with the baby.

...I've enjoyed it. I've enjoyed the contact of it. I shall be quite sad to give it up really. Quite nice to continue with one feed at least for quite a while.

(Hilary:1:3:14)

Michelina, the Italian mother, had a particular reason which was unique in this

study for maintaining the breastfeeding relationship with her baby. She lived in an extended household where child-care was shared with female relatives while she worked most of the day in the family business.

That's the only feed she has now breastfeeding, and I have to wake her up sometimes, and she'll suck for a good quarter-of-an-hour, twenty minutes, and she's got to the stage where I think that she knows who her mother is cos she sort of looks at me in her eye, then she sort of starts going, gooh, you know, she starts sort of goohing, and it really is lovely to think that she knows, you know, the mother, who it is...because she sees so many people every day, for example my mother-in-law, my sister-in-law, and I think it might be a bit difficult for her to distinguish who is who, whereas as I feed her in the morning I think she's getting to know who the mother is. It's just lovely. I just think she knows, you know, who I am.

(Michelina:22:3:1-2)

With growing confidence mothers found getting out and about less of a problem, and were in more of a position to realise the benefits of a feeding method that is always instantly available, without preparation, and does not require carrying equipment. Middle-class women were often aided by having social lives which revolved around visiting the homes of friends where they felt confident either that the people there would not be embarrassed, or that the use of another room would be easily available.

I used to find it quite difficult in the early stages...Actually

if I went out to coffee with somebody, to feed him, I felt self-conscious, and I thought, 'Well, if he starts crying or doesn't get on right, I'm going to look stupid.' I used to feel he never fed as well, but I think it probably was that I was a bit up-tight, and never seemed to get enough, because he'd never go as long after the feed if I'd fed him out. I don't have that problem now. It's just practice.

(Gwen:44:3:14)

...I got stuck in Caterham the other week, the other day, because my car played up. I was still able to feed him. Well, if I'd been out for the afternoon with bottles I would probably only have taken enough for the afternoon. I needed them for the night as well.

(Marcia:35:3:11-12)

But managing feeding when out did not become easy for everyone.

Well, just sort of like now we'd like to take him out for the days and things, and it is a bit inconvenient lunch-times and that. Have to find somewhere to feed him. We have been out and I've fed him in the car and that, but it's all right when there's no one about, but this time of year there's lots of people around...I think if I can keep going till six months, I think that should be long enough.

(Isobel:31:3:4)

Even women who did find feeding could be easily managed could still feel drawbacks.

I usually go upstairs in their bedroom if we're out at some friends' or something.

(Interviewer: Does that work all right? I mean do you find it a nuisance having to go upstairs?)

Yeh, because you lose out on the conversation.

(Pauline:34:3:6)

But two women seemed to gain enough confidence to be able to feed virtually anywhere. One was the feminist who had always intended to assert her right to breastfeed wherever she chose. She was not worried about what other people *might* be feeling, and she found that people did not make direct attacks on her behaviour.

By the time he was two months he was able to latch straight on and have a good feed enough to satisfy. And having done it once on my own and realised nobody came up and told me anything horrible, then that was all right.

(Maureen:11:3:19)

Samantha saw no harm in feeding discreetly (i.e. not showing very much).

...by the time we went on holiday, at three months, we'd probably reached our peak of breastfeeding. I mean he was happy and I was producing plenty and he was quite settled...I don't know how we would have coped with flying all that way, because you obviously couldn't have all the bottles prepared necessarily exactly when you wanted...And also sort of hanging around air-ports. He invariably wanted feeding as we were taking off or

landing, and if he was crying it was so easy just to give him an extra feed...And on holiday, that was wonderful as well. I mean I sort of fed him all over the place. On the beach, walking along, sitting in shopping centres and-, fairly discreetly, but I mean it didn't worry me in the slightest. It was just so convenient.

(Samantha:27:3:4)

But embarrassment could wipe out this sort of advantage completely, even for middle-class women, in which case breastfeeding was the feeding method which prevented complete freedom of movement.

...On the aeroplane it was very inconvenient. Although they gave me a seat that was supposedly for nursing mothers, it was right out in the middle of the airplane, and everybody walking by could see what I was doing, and I was very uncomfortable. And of course while we were away it was the same sort of situation. I never had any privacy, and that pretty much turned me off the whole situation.

(Roberta:46:3:1-2)

...that's what was, in the end, not until she was about, say, three months, beginning to get me down a little bit, because I felt I was forever feeding which was restricting really what I could do. I mean as much as somebody'd say, 'Oh, come round and see me.'...I couldn't see

anybody too far away because I took her on public transport and I can't sit on the bus and feed her, and then you'd be arriving with a screaming baby...

(Anneka:5:3:13)

Most women remained reluctant to claim a right to feed anywhere.

It's all very well saying I'll feed wherever I want, but I think in an intimate situation you've got to be considerate of their feelings as well because whilst you might say it's quite-, it is natural and that sort of thing, it's just that some men, particularly if they haven't had children themselves, could be very embarrassed by that.

(Irene:3:3:17)

Here is an indication of an upper middle-class mother accepting the idea of breastfeeding as contaminating despite her objection to being relegated to the toilets.

...you're right in the loos and there's a lot of noise, and you sort of feel it's not as hygienic possibly, although it's not really a hygienic thing when you're breastfeeding, is it?

(Gwen:44:3:14)

But many breastfeeding mothers continued to argue strongly that a big advantage was not having the work of preparing feeds or sterilising bottles. In fact, for some breastfeeding had become so simple that they found having to introduce solids a nuisance, because it involved planning, preparation and equipment.

It's so easy to breastfeed. There's hardly any preparation.

Well, there isn't any preparation, apart from sitting down with a box of tissues, whereas now you have to think a bit more, and more responsibility I suppose...

(Ruth:37:3:9)

I find it much more of a hassle now, going out thinking I've got to take solids, and bits and bobs with me, than I ever used to before. Which would be the same if you were bottle-feeding, I suppose. *You've always got to* remember to take the bottle, warm it up, all those sort of things.

(Gwen:44:3:20)

On the other hand, for some mothers who did not find breastfeeding so simple, getting the baby established on solids helped ease the problems. Two combination feeders, Hilary and Nancy, instead of phasing out the breastfeeding at this stage were able to phase out the bottle. Hilary had been feeding one bottle of formula a day so that her baby was accustomed to an alternative to breastfeeding for public places or leaving him with a sitter. Once solids were established these provided another socially acceptable means of feeding the baby, and so the bottle was dropped before four and a half months. Nancy had been supplementing with formula because she felt her milk was not totally adequate, but solids provided an alternative source of food and meant that the baby was no longer so dependent on milk anyway, and so the formula supplement was dropped at six months.

Similarly, once solids were established, full breastfeeding mothers could phase out the least convenient breastfeeds, but continue with the ones they enjoyed or which

had their own convenience. Most typically this meant that day-time feeds were phased out first, but mothers continued giving an early morning feed as a means to give a pre-breakfast snack and drink to the baby without having to get up early, and an evening feed as a comforter to get the baby settled for the night. The mothers now generally expected their babies to sleep through the night, but if they did wake, breastfeeding again provided an easy way to settle them again.

#### 11.4 CONCLUSION

Although the mothers were often anxious about beginning weaning, and sought information, by this stage they had gained in confidence, they were more independent in their judgements and they had supporting peer group networks. But these things came too late to be much help with breastfeeding, as most of the problems had occurred in the early days. But for those mothers who overcame early problems and eventually settled into happy breastfeeding relationships, there came new reasons for being put off breastfeeding. As the babies grew perceptions of the value of breastfeeding diminished, it was no longer actively encouraged by health officials, and it became increasingly deviant to be still breastfeeding even in peer groups. This applied more to working-class than middle-class mothers. Those who found breastfeeding onerous could give up without feeling guilty, but those who wanted to continue now had to justify themselves by citing their own convenience or not upsetting the baby, because the assumption of benefit to the baby was no longer there and it was no longer expected of them.



## **CHAPTER 12: COMPLETION OF WEANING**

Twenty-one women breastfed beyond the age of six months, which in this study is regarded as having breastfed to the end of the weaning process since after six months the babies were all on a mixed diet, they were capable of drinking from feeding cups, and, according to expert advice as well as in their own perceptions, their babies could be nourished adequately without breast milk or specially formulated substitutes. A few women used bottle-feeding as a transitional stage after six months, i.e. two combination feeders (Michelina and Donna) phased out breastfeeding before stopping bottle-feeding, and two breastfeeders (Edwina and Angela) reported resorting to bottles to ease the withholding of the breast. But in general at this stage the weaning process was completed without any transitional use of bottles.

### **12.1 LACK OF KNOWLEDGE AND EXPERT ADVICE**

The women were far less dependent on expert advice than in the early days of motherhood and were more confident in making their own day-to-day judgements. But they approached stopping breastfeeding with a certain amount of uncertainty. They felt that whereas there had been advice and help forthcoming in the early days to encourage them to breastfeed, there was nothing to guide them in how to give it up, i.e. how to persuade their babies to do without it, and how to avoid engorgement. In the event they seemed to manage without too much trauma. Whereas mothers who had wanted to give up breastfeeding by six months (e.g. Anneka, Andrea and Fern) had encountered problems trying to persuade their babies to accept a bottle instead, after six months the mothers could make a smoother transition on to feeding cups in the baby's own time. They also found that their milk adjusted to the gradually diminishing demand so that

engorgement was not a problem.

## 12.2 CHANGING PERCEPTION AND EXPERIENCE OF BREASTFEEDING

### 12.2.1 Breastfeeding as a Norm

The older the babies became the more deviant breastfeeding became. On the whole working-class women felt this before middle-class, although the general pattern was for day-time feeds to be phased out first so that those mothers still breastfeeding were unlikely to be doing it at times and in places where it would be apparent to other people anyway. None of the women thought it appropriate to be still breastfeeding beyond a year.

I had been thinking in terms of probably around about eight or nine months, but again depending really how things go. But I think I'd like to have stopped before he's a year. I don't know. It's just a-, funny, we were discussing this at one of the things...the group thing that we'd had, when we all get together, cos quite a few of them breastfeed, and it seems it's all right, it feels all right when they're babies, but when they get that bit bigger something doesn't feel quite right about having them breastfeeding. And it's funny, most of us felt the same way, cos I mean we'd heard of people that did it, you know, two or three (years), which somehow didn't appear quite...

(brackets added)

(Cynthia:14:3:13)

Breastfeeding is culturally associated with 'nature' and we have already seen how mothers feel constrained to keep it hidden because it can cause embarrassment and disrupt cultural activity. One factor with an older baby could be that as it is becoming socialised it is less associated with 'nature' than the newborn, and it is therefore that much more disturbing to cultural expectations for an older child to be still breastfeeding, an activity which can seem more animal-like than human. One woman, who breastfed for nearly eight months, said that breastfeeding a baby over a year did not 'look clean' (Pauline:34:3:14).

Two mothers were in fact still breastfeeding when contacted after a year, but only about once a day, and both anticipated that their babies would give up these feeds soon.

#### 12.2.2 Benefits to Baby

After six months the mothers no longer saw their babies needing the particular nutritional and immunity-conferring qualities of breast milk, and even though they continued breastfeeding they saw it less and less as a significant part of the baby's diet. But they still felt that their babies derived physical and psychological comfort from breastfeeding, and they were reluctant to upset them by too forced a withdrawal, although the mothers used varying degrees of withholding breastfeeds and letting the baby give up of its own accord. One incentive for not maintaining breastfeeding for longer than a year was the fear that it might be habit-forming and therefore become harder to persuade the baby to stop.

...Also, I don't really like the idea of feeding him when he is over a certain age...I think the longer you leave it the harder it gets to stop them, i.e. it's easier to stop when they're a baby than it is, say, when they're over a year.

Um, (laughs), lady down the road...her son is...two...She's still breastfeeding him, and she says it's terrible because she can't stop him. At night-time, or whenever he falls over and he's upset, he comes and gets on her lap and gets into position and brings a mug of water with him and has a drink in between.

(Vanessa:12:3:5-6)

### 12.2.3 Benefits to Mother

All the mothers who continued beyond six months derived enjoyment from it. In general the less mothers felt inconvenienced by breastfeeding the longer they continued. On the whole they felt it was easier to continue breastfeeding and avoid a transitional stage of bottle-feeding. As day-time feeds were phased out first, which were the most likely to clash with other activities, as time wore on mothers were continuing only with the feeds which were convenient to them, in particular, in the evening breastfeeding was an easy way to get a baby off to sleep, and similarly if the baby woke in the night.

The mothers often anticipated that teething would necessitate stopping, because they feared being bitten. However, on the whole such fears proved unfounded. A few women did complain of actually being bitten and cited this as one of the reasons for stopping breastfeeding (e.g. Donna and Edwina), but in most cases this was not mentioned as a problem and did not prevent the continuation of breastfeeding.

All the women who gave up breastfeeding after six months were glad that they had breastfed, and some argued strongly that overall it was much more convenient than bottle-feeding. However, most expressed at least some ambivalence on this point. They

had not forgotten the early problems, they stressed the need for perseverance, and the social unacceptability of breastfeeding in public and lack of facilities to retire temporarily from the public view had caused problems.

I think bottle-feeding's easier, but I would always breastfeed. Breast is obviously best for them, and it's a beautiful experience...The problem is that you don't know how much they're getting, and there's this business about you're the only person that can really feed them. I mean, OK, you can express, but I mean I bought a breast-pump and tried that, and it didn't work very well...and also they can always smell it on you, so if you're cuddling them there's always this sort of nuzzling business. I mean if a baby's anything like her, I mean she would suck all day if I let her. I mean the whole time she would be attached. Which is lovely, but it's not terribly convenient. There are times when you want to go on with work and what-have-you...I think it must be easier if they're on the bottle to get them on to solids and normal feeding. I think it's less traumatic for them to lose the bottle than to lose the breast I think, because there is such an emotional thing involved. I mean I'm lucky now that she's found her thumb, because that's a comfort to her, and she will go to sleep sucking her thumb now, but it's only just recently. I mean the last week or so. Before that she wouldn't, the

only way she would go to sleep was plugged in, you know (laughs). Which means that you're very, very bound. I mean I'm the only person that could get her to sleep, so baby-sitters and so on were just not possible. I mean my friends that have got their babies on the bottle now, this girl at Ascot, she can leave her babe...with a bottle and a baby-sitter, and go out, and at the moment we can't do that really. So it is a tie. I don't think that's explained to you in hospital at all...It just seems a lot easier to have sort of five bottles of milk all lined up there, and that's what they have during the day, and you can see what they've had. It just seems a lot simpler...

(Andrea:17:3:13-14)

I just used to take a bottle with me. If we went out shopping or something and it came time for a feed, I just used to take a bottle with me. If I used to forget it, I used to have to go and sit in the toilets. There's not a mother and baby room or anything. Ridiculous.

(Milly:33:3:8)

I think I wouldn't say one was easier than the other. Depends how you look at it. With breastfeeding obviously you haven't got to sterilise anything, so it's just there and it's with convenience. But if you go out, it's nicer to be able to take a bottle along with you, already made up with

the feed in. You're not sort of-, I don't know. I suppose breastfeeding really. I mean that's more convenient.

(Pauline:34:3:10)

Oh, breastfeeding I think must be-, is a lot easier. It's just sometimes a bit inconvenient, but it's a lot easier than making up all the bottles and sterilising everything.

(Interviewer: When you say inconvenient, are you thinking of the going out?)

Yeh. Just for that. We don't go out much, but just when you do want to, obviously it's a lot easier to leave a bottle with someone. I mean I have done that a couple of times, but if you want to take him with you and that, it's a bit of a nuisance having to go up to someone's bedroom for half-an-hour. Miss out on all the conversation and things.

(Isobel:31:3:32)

#### 12.2.4 Looking Back and Looking Forward: Mothers' Appraisals

Looking back from the five-month interview, even those who were most happy with breastfeeding recognised difficulties, especially in the early days. When asked what advice they could give from their experience to new mothers wanting to breastfeed, they stressed the need for perseverance, patience and determination.

I would definitely say if you're having problems with breastfeeding at the beginning, persevere because they do go away, even though you think they're going to last forever, and it is worth it in the end. Not to be in too

much of a hurry, because he'll settle down to the same routine in the end.

(Marcia:35:3:17)

Perseverance. I found the best way to cope with anything is to-, if he-, like if he plays up at all, to think, 'Oh well, tomorrow will be better,' as opposed to, 'Oh, is this how life is always going to be?'

(Cynthia:14:3:17)

I think you have to be positive and feel that you want to breastfeed to be able to succeed. I know some women find it impossible. I think you've got to want to, to be successful. And I wanted to.

(Ruth:37:3:10)

They also needed to learn how to be independent.

Just relax. Not to get up-tight and worry about all the advice. I mean, that has been the worst thing I think. So much conflicting advice that you really don't know what, you know, unless you start using your own common sense and using your own initiative...

(Andrea:17:3:25)

In contemplating feeding a second baby, breastfeeding remained the most popular choice. Of the women who had chosen to bottle-feed, Trudie thought she would try breastfeeding her next baby, and Lorraine thought she might try it for about two days. Diana, who had been prevented from breastfeeding through her treatment for cancer,



still wanted to try it. Fay still wanted to bottle-feed, but with the same reservations she had at the beginning of the study, and Brenda remained as confident as ever in her choice of bottle-feeding. Of the twelve women who gave up breastfeeding in hospital or soon after returning home, all except three wanted to try breastfeeding again. Of the nine who gave up breastfeeding during the early weaning period, Fern thought she would probably bottle-feed her next baby, and Françoise said she would only breastfeed a girl. All the rest said they would breastfeed again, and four said they would do it for longer.

All the women who breastfed through to the later weaning period said they would breastfeed again, although often with provisos. They anticipated that they would be helped by their previous experience of breastfeeding - they would not be entering an unknown mystery, they would have more self-confidence and they would be far less prone to anxiety. But they would have the additional factor of an older baby to care for as well, and they wondered how far this would allow them the time to devote to breastfeeding which they had spent with the first baby. Several also said that they would make a point of accustoming the next baby to bottle-feeding even though they had confidence in their breastfeeding capabilities, so that when they needed an alternative method for feeding in public or for leaving the baby with a sitter they would not have to worry about the baby rejecting the bottle.

I must admit I think I would find it a little bit trapping if he point blank refused to have anything else...But I don't actually particularly like missing feeds. I don't do it very often. I think it actually helped in a sense though, because a lot of people who won't take the bottle, or their kids won't take the bottle, is because they didn't actually give

it to them. I think if I had another child I would actually try and make sure they took a bottle at some points in the early stages just so that they would take...

(Gwen:44:3:13)

If he hadn't taken to a bottle as well as breastfeeding, then I would have had problems definitely because the facilities just aren't there, but when we go out and I think I won't be able to breastfeed very easily I take a bottle, and he has that, and he's quite happy.

(Hilary:1:3:4)

Overall, then, in the light of their experiences of feeding their first babies, fewer women wanted to breastfeed their second, although the drop was very marginal. In fact, few women were put off by their experiences of breastfeeding sufficiently not to want to do it again. On the other hand, the women were still aware of drawbacks. The fact that a substantial number of those who had successfully established breastfeeding still foresaw difficulties with a second baby, and anticipated using bottles as an addition to breastfeeding, shows that the pull to bottle-feeding is not just a matter of women's ignorance of how to breastfeed.

## **CHAPTER 13: CONCLUSIONS**

This study of mothers undertaking the task of feeding their babies has shown the sorts of problems encountered by women attempting to breastfeed in our society today. But the evidence can be construed in different ways according to theoretical standpoint. It was pointed out in Chapter 2 that there is not one feminist perspective but several. There is also the question of whether feminism should be pro-breastfeeding or pro-choice. In this conclusion I want to try to unravel some of these different strands and see what different conclusions they lead to. In Chapter 3 I referred to Oakley's study of the transition to motherhood (Oakley, 1980). As breastfeeding is bound up with becoming a mother, Oakley's analysis of the way social control is maintained over women in this aspect of their lives is relevant to their experiences of breastfeeding. But ultimately the interpretation of the evidence given by the women in this study will vary according to whether one takes an 'essentialist' view of women, or whether one gives priority to the various views expressed by the women themselves.

### **13.1 BREASTFEEDING AND THE SOCIAL CONTROL OF WOMEN**

Oakley (1980) has argued that women's reproductive role makes their social disempowerment necessary for the maintenance of male dominance. Social order depends on the demarcation of boundary lines between nature and culture (Levi-Strauss, 1969), and in giving birth women straddle that demarcation through, on the one hand, 'the biological emptying of the uterus' and on the other 'the social character of its product, a child' (Oakley, 1980, p.8). Men are dependent on women in the reproductive process, as only women can give birth, and so for women to be in control of their own reproductive power threatens male dominance. In our society women are also culturally

identified primarily with motherhood, and in their social role as mothers and housewives the tasks which are assigned to women (nurturing children and doing the work of meeting basic human needs for food, warmth, comfort, etc.) again involve women at the boundaries of nature and culture, transforming natural products into cultural (Ortner, 1974). How are women therefore culturally contained?

In Chapter 3 it was shown how women are culturally defined not only as different from men, but also inferior to them, helpless, dependent, and subordinate to the needs of others. Women continue to be disempowered through socialisation, cultural attitudes and social structures. Oakley's study (1980) shows how women's transition to motherhood in our society is not an experience of achievement in what is women's 'authentic achievement' (p.291) in an area of life which women can claim as their own. Rather it is an experience which encourages feelings of helplessness and low self-esteem. The women in this study, in becoming mothers, faced the same sorts of problems mentioned by Oakley: loss of control over the actual birth to a male-dominated medical profession; loss of social identity and self-esteem through having to give up employment outside the home; loss of social contact and outside interest and loss of income. Lack of knowledge of babies also caused anxiety and feelings of failure and guilt in meeting the awesome responsibilities of caring for a new baby.

The difficulties faced by the women in this study as they undertook to feed their babies were also of a kind to contribute to feelings of helplessness, anxiety, failure and low self-esteem. Oakley distinguishes two ways in which male control over women's reproductive power has been achieved historically: *separation* and *incorporation*. Both can be applied to the women's experiences of breastfeeding.

Breastfeeding is '*separated*' from everyday social discourse by cultural

devaluation. Women are encouraged to do it in order to confer benefits on their babies, and it is therefore part of the image of the 'good mother', and yet as a 'natural' function it is seen as a source of revulsion or embarrassment. The women in the study therefore felt constrained to keep breastfeeding hidden.

There were four types of evidence for this in the study.

1. Breastfeeding being seen as a source of revulsion through being associated with animals/cultural backwardness/contamination.
2. Conflict with the cultural definition of breasts in terms of sexual attractiveness to men, causing husbands to feel jealous, either of breastfeeding itself or of their wives being seen doing it.
3. The feeling that breastfeeding, as a natural function, should be done in private. The women were not repelled by breastfeeding itself, but thought that it should be kept hidden.
4. The effect on the women of other people's embarrassment and disapproval. There were some examples of mothers being directly subjected to expressions of disapproval or refusals to tolerate the sight of breastfeeding, but mainly it was the assumption and fear of other people's reactions which constrained women not to risk breastfeeding in front of others.

There was variation in the sorts of situations where the women felt breastfeeding could not be done or the sorts of people it could not be done in front of, and there were examples of mothers trying out breastfeeding in what were perceived as potentially difficult situations and therefore successfully extending their boundaries. But all the women had the experience at some time of feeling constrained to hide their breastfeeding from other people. In fact, few mothers fully realised the potential freedom of

movement afforded by a feeding method which requires no special preparation or equipment. Rather it was bottle-feeding which gave the mothers freedom of movement into the public sphere, as resorting to bottle-feeding was the usual method of managing moving into areas of cultural activity.

The cultural devaluation of breastfeeding also meant incompatibility with other standards of success for the women. For instance, cultural images of femininity define certain aspects of breastfeeding as unattractive, e.g. over-enlarged breasts, unglamorous bras and clothing restrictions. This image of femininity was maintained by the health professionals when they encouraged the expectant mothers to value breastfeeding for themselves in terms of its helping to restore a slim, pre-pregnancy figure.

But this separation from the public sphere does not entail women being in control through having an autonomous female knowledge based on experience of breastfeeding which can be passed on from generation to generation. Breastfeeding is '*incorporated*' in that knowledge of it is legitimated by 'science', and the ultimate authority is the male dominated medical profession. The changing nature of 'scientific' knowledge makes women's knowledge based on experience seem quickly out-of-date. This, together with the women's lack of contact with babies and breastfeeding before having their own babies, meant that they were dependent on the professional expert sources of knowledge emanating from the medical profession and the manufacturers of alternative baby-foods. Although the giving of practical help and advice is left to female health workers (midwives, nurses and health visitors) they work under the authority of the male dominated medical profession, and are 'qualified' by professional training rather than their own personal experience of breastfeeding. (The NCT breastfeeding counsellors were exceptions here, but this is a service provided, and used, by women on their own

initiative as a response to perceived inadequacies in the officially provided services.)

But this dependence on experts did not result in a system by which the women received clear instructions on how to proceed. The organisation of maternity care meant that expert help and support were impersonal, lacked continuity, and were not always available when needed. The women were also seriously affected by the lack of clarity and consistency in the advice they received. Bottle-feeding was ever-present in medical advice and practice as a reliable substitute, and readily advised as the quick and efficient solution to problems.

Altogether then the women's experiences were structured in a way which would encourage feelings of anxiety and failure, and would work against their gaining a sense of personal pride and achievement in an ability which demonstrates women's difference from men.

But the interpretation of circumstances and the women's responses, can vary depending on whether one takes an 'essentialist' view of women as mothers, or on whether one takes account of the views of the women themselves.

### 13.2 AN ESSENTIALIST VIEW, AND THE WOMEN'S VARYING VIEWS

The essentialist argument rests on assumptions about the 'nature' of women stemming from their biological difference from men. Human beings have physical bodies, and how they experience their bodies is therefore an important part of human experience. Rich (1977) argues that as only women can give birth, motherhood is an important human experience for women. Giving birth and breastfeeding are part of women's unfolding life-long experience of their own unique sexuality, which so long as women are truly in control of their own bodies and lives are potentially blissful and fulfilling experiences. But this is prevented by cultural devaluation and loss of control

to men in patriarchal society. According to the logic of this view this is what alienates women from breastfeeding or prevents them from being able to do it (and for women not to realise this is a sign of false consciousness).

Therefore for women to choose to combine breastfeeding with bottle-feeding is viewed as evidence of their being rendered dependent on manufactured products and being deprived of fully realising and demonstrating the self-sufficient power of their bodies. In the same way other products manufactured to aid breastfeeding are viewed as the result of the profit-making motive, and women are persuaded that they need them for reasons which are inimical to breastfeeding. Thus nipple shields are a substitute for correcting the baby's latch, or learning to express milk from an engorged breast, and contribute further to the problem of sore nipples by accustoming the baby to an inappropriate latch. Similarly nursing bras are needed to preserve one's 'figure', and pads prevent 'embarrassing' leaks. Pumps are again substituted for learning to express by hand, and are necessary, together with bottle-feeding paraphernalia, to avoid causing embarrassment in public, or to allow going out without the baby to places where babies are not welcomed, or so that the husband/father can also feed. Thus also the phenomenon of women choosing to give up breastfeeding in the early weaning period, or not wanting to continue beyond the first year, is viewed as the result of cultural devaluation of breastfeeding - through women being led to view breastfeeding as of little or no value beyond the first few weeks and to believe that manufactured products are better, and through breastfeeding becoming less socially acceptable the older the baby gets.

This essentialist view invites the formation of a utopian vision of the sort of society in which there would be nothing to distract from women's experiences of their



bodies and mothering being totally fulfilling human experiences. The 'natural ideal' rests on the idealisation of a pattern of life supposedly associated with simpler societies less divorced from 'nature' than our own, and this could seem to provide a blue-print for just such a utopia. In this vision there is a unity between motherhood and other aspects of life. Baby care is integrated into the organisation of work, leisure, religion, and other cultural activity. A girl grows up becoming familiar with babies and absorbing a coherent body of knowledge about babies and breastfeeding which is shared between females. On entering motherhood she is supported with practical help and advice from experienced mothers, and her needs as a mother are catered for in the organisation of work and other routines. Consequently she can be constantly with her baby, continuing its nurture from her own body as before birth, without being excluded from other cultural activity. In this idealisation breastfeeding is culturally valued as part of the process of bringing new life into the world. Women can therefore gain a sense of their own physical power and social worth by breastfeeding. They can also enjoy a unique relationship with their babies which is mutually beneficial and fulfilling.

This sort of feminist view is pro-breastfeeding in a similar way to the non-feminist pro-breastfeeding views, since the unity of mother and baby again identifies the mother's needs with her baby's. So this implies that feminism should be advocating breastfeeding and helping to educate in the principles of the natural ideal. The difference between this and the non-feminist lobbies would be that the feminist view would look beyond the immediate obstacles to breastfeeding and work also to change the patriarchal structural arrangements and cultural assumptions which lie behind these obstructions.

But the natural ideal is based on an idealisation of pre-industrial societies which

in practice would have had some aspects we would not want to return to, and which also had their own mechanisms for maintaining women's subordination. It may provide a good starting point for ideas on the sorts of social changes needed (e.g. women sharing knowledge and management of their own reproductive powers, and integration of baby-care into other cultural activity), but we need to consider the power relations of today, and utopia will not be achieved merely by harking back to a supposed golden age. Another problem with this approach is that it makes assumptions about women's nature, and how they ought to feel, in a positivist way, and does not take into account the women's interpretations of their own experience.

For instance, whilst there were mothers in the study who felt a sense of failure or guilt about resorting to bottle-feeding, and who avoided it as much as possible, there were also mothers who gained a sense of greater autonomy from it. These were women who felt they were making their own decisions and used artificial feeding purposefully, by, for instance, the use of combination feeding (e.g. Hilary, Connie, Françoise) and/or breastfeeding only into the early weaning period (e.g. Connie, Françoise). These women went to considerable trouble to establish breastfeeding in the early days, often enduring a great deal of discomfort, and so being able to breastfeed was obviously important to them. But they introduced bottle-feeding when it suited them without apparently any sense of guilt or failure. It was also common for mothers who had successfully breastfed to the completion of weaning to contemplate purposefully keeping their next baby accustomed to both breast and bottle-feeding from an early age so that they would always have an alternative feeding method available.

From the feminist essentialist point of view these examples could be dismissed as 'false consciousness' and as examples of women being passively influenced by

cultural devaluation and hostile social structures. But to do so would overlook the extent to which these women were making their own decisions and were actively engaged in ordering their lives. How the mothers felt and experienced their breastfeeding would depend on the meanings things had for them. On the one hand ideology could be viewed as supplying meanings, but on the other hand, in the face of contradictory meanings and conflicting pressures the women could be seen as actively engaged in choosing meanings in justifying their decisions.

If women feel pressured to breastfeed when they do not want to, then this would also be an experience of losing control over their own bodies and lives. From this point of view, feminism would be pro-choice rather than pro-breastfeeding. From this perspective some of the evidence can also be construed differently taking into account the women's actual feelings and responses. Thus, for instance, having the husband/father (and sometimes other people as well) share in feeding was overwhelmingly experienced by the women in the study as a genuine help and a sharing of a pleasure and responsibility, rather than the unique power of women to feed babies being undermined and made into a task anyone can perform. There were also many instances of the mothers finding the products manufactured to aid breastfeeding helpful. For instance, many women described nipple-shields as *the* essential item which enabled them to carry on breastfeeding during early difficulties, without the shields apparently preventing the development of an appropriate latch for continued breastfeeding. Thus also with modern methods of hygiene and easy availability of suitable foods for older babies, it seems reasonable to see no necessary or unique protective benefit for babies from breastfeeding as they grow older, especially in the second half of the first year.

From this point of view, too, the natural ideal can be construed as setting

unattainable standards in our society, and contributing to women's feelings of guilt and failure when they fail to attain the ideal. Middle-class mothers, especially NCT members, who had greater exposure to the natural ideal were more 'successful' at breastfeeding in terms of how long they breastfed and how much they resorted to artificial supplements, and yet it is arguable whether they experienced any less guilt or failure in overcoming their difficulties than mothers who chose feeding methods to suit their own needs and/or who saw it as normal to phase out breastfeeding in the early weaning period.

It is therefore worth considering what sorts of meanings the natural ideal supplies, and whether it could have an anti-feminist ideological function. The natural ideal, with its emphasis on unity of mother and baby, and feeding on demand, bolts the mother to her baby and makes her subservient to its needs, and can thus be seen as reinforcing some of the key mechanisms which have been identified for maintaining male dominance in our society - the identification of women with motherhood, their subservience to the needs of others, and, with babies and especially breastfeeding segregated to the private sphere, their exclusion from the public sphere and positions of public influence. Through its incompatibility with other cultural assumptions and social arrangements, it also has the potential to contribute to women's anxiety, sense of failure and guilt in the transition to motherhood, which is part of the lowering of self-esteem and loss of a sense of achievement which Oakley (1980) has identified as useful to the maintenance of male dominance.

### 13.3 BREASTFEEDING, SOCIAL CLASS AND POWER

As I am considering breastfeeding in terms of women's social power and how they are socially controlled, it is appropriate to give some consideration to class

differences in breastfeeding rates, and whether differences in the power and autonomy of middle- and working-class women affect breastfeeding.

Despite the variation in ideas as to the value and duration of breastfeeding, the majority of mothers in the study did say at the first interview that they wanted to breastfeed and subsequently attempted to do so. Middle-class women were more successful than working-class in terms of overcoming initial problems and establishing a breastfeeding pattern (with or without varying degrees of reliance on bottle-fed supplements). For the mothers to establish breastfeeding despite so many hindrances took determination and perseverance. In these circumstances it is to be expected that it will be the women with the greatest self-confidence and control over their lives who will manage to keep going in their attempts to breastfeed. The middle-class women in the study were helped by breastfeeding being more of a sub-cultural norm to them, and by greater exposure to the ideas of the natural ideal (especially through the NCT), but, more than this, they were also women who would have greater self-confidence through their higher social status, and previous educational and career achievements. They were also, on the whole, older than the working-class women. They were less fatalistic, and more independent of conventional ideas of femininity. In addition, they tended to have more equal power relationships with their husbands who were more willing to serve the needs of their wives as they struggled to breastfeed.

For the working-class women breastfeeding was less the sub-cultural norm, but this was changing in that they looked on it as something which had become desirable in light of scientific discoveries of its benefits for babies, and it was now normal to want to breastfeed even if they seldom knew of anyone in their acquaintance who had succeeded. However, they were more exposed to clashing ideas since their own

knowledge and that of experienced mothers around them was based on bottle-feeding and reflected more the assumptions of the medical model, and their only source of ideas reflecting the natural ideal came from medical professionals. Many of the working-class mothers were in stable relationships and a secure financial position, but some were far less advantaged in this respect than the middle-class women. Their educational and career achievements were much lower, some of them were the youngest in the sample, and some showed far less clear planning in the circumstances of their becoming pregnant. They were more fatalistic, especially in their attitudes to breastfeeding, and were more dependent on conventional ideas of femininity, including the better-off working-class women who seemed particularly concerned about maintaining a respectable, conventional image. They also expected less support from their husbands, and were more concerned about the possibility of their husbands being jealous or annoyed by inconvenience.

So, whilst there are some sub-cultural differences in attitudes to breastfeeding, the difference in success at breastfeeding between the middle- and working-class mothers seems to be linked also to the greater social power and independence of middle-class women.

Most of the working-class women who maintained breastfeeding can be seen as having been helped by certain advantages not generally available to other working-class women (or, for that matter, the middle-class mothers): e.g. helpful advice and support from an experienced mother (Pauline, Cynthia, Michelina), their own extensive previous experience with babies (Gaynor, Fern), or an independence of mind (I might even say 'cussedness') manifest in the fact that they were already actively breaking social norms and standing up for themselves in certain other aspects of their life-styles (Donna,

Milly).

Efforts to increase breastfeeding in recent years have concentrated on convincing mothers of the need to confer on their babies the benefits of breastfeeding, and on improving the help and advice they receive when they try to do so. As far as imparting knowledge of the benefits of breastfeeding is concerned, health education efforts have been successful. All the mothers in the study were aware of the arguments in favour of breastfeeding, and most wanted to do it. As for the conflicting ideas which hampered their attempts to breastfeed, much effort is being made by experts to establish a coherent framework of ideas which reflects the natural ideal. Advice books on breastfeeding promulgate the natural ideal (e.g. Kitzinger, 1979; Stanway & Stanway, rev. 1983; La Leche League International, rev. 1988); Renfrew et al., 1990), and the same ideas are superseding the medical model in literature distributed free through the NHS. The Royal College of Midwives has published a booklet for its own members in order to encourage greater consistency in the advice and help given to mothers by midwives (RCM, 1988). But such a clear coherent knowledge could only alleviate problems for the mother in the physical skills of breastfeeding. It will not solve the problems of cultural devaluation and incompatibility with cultural activity. Mothers would still have reasons for not wanting to breastfeed, or for supplementing with bottle-feeding. Artificial feeding has an established place in our society today, even in the management of breastfeeding.

But the more influential the natural ideal becomes, the more having to resort to bottle-feeding, whether for nutritional or social reasons, is likely to represent to mothers a compromise, a failure to achieve the ideal: either their bodies have failed to supply the nourishment needed, or they were not sufficiently self-sacrificing or well organised to cope with breastfeeding and the other demands of their everyday lives. A lack of belief

in the superiority of breastfeeding could therefore protect the self-esteem of some women, for instance the working-class women in the study who saw less difference in benefit between breast and artificial feeding. When the benefits of breastfeeding were seen as rapidly diminishing, women who gave up in the first few days or weeks could still feel a certain sense of achievement from having given the baby 'a good start', and those who gave up in the early weaning period felt they had breastfed as long as was necessary and expected of them anyway. When middle-class women resorted to bottle-feeding for social reasons, many tried in the first instance to express their own milk for this purpose. Those who gave formula, or became combination feeders for their own convenience, could justify their action if they believed that a certain amount of formula feeding would not compromise the baby's well-being, whereas the strongest adherents to the natural ideal were more reluctant to make this compromise.

Although working-class women on the whole did not see the superiority of breastfeeding as so great and were less affected by the natural ideal, they were by no means free from experiencing guilt and self-doubt. Before the birth working-class women on the whole seemed to have a clearer perception of the practical difficulties of integrating breastfeeding into their everyday lives, and yet of those who chose not to breastfeed at all only Brenda, a mature woman (aged 30) had no doubts or regrets in her choice, being unconvinced that breastfeeding was a superior feeding method in any way. All the younger working-class women who bottle-fed acknowledged that breastfeeding did have health advantages for babies, and admitted to doubts and regrets. In choosing to bottle-feed they were implicitly admitting that they were not prepared to try to do the best for their babies, or that they lacked confidence in their own bodies. So, despite making a choice which enabled them to manage the practical tasks of feeding their



babies within their social context, their health education in breastfeeding was a force to undermine their sense of achievement and self-worth as mothers. In fact, this served to undermine what could have been seen as an advantage over middle-class mothers in taking to motherhood with confidence, since on the whole working-class mothers had more familiarity with babies and closer ties with experienced female supporters. Whereas the middle-class women felt completely lacking in knowledge of babies and feeding methods in general, the working-class mothers' lack of confidence was often centred more on just the breastfeeding while they were in a position to take on bottle-feeding more confidently.

#### 13.4 SO WHAT CAN BE DONE?

Educating women as to the merits of breastfeeding and providing coherent information, based on the assumptions of the natural ideal, on how it should be done will not eliminate all the contradictions faced by mothers. There are attempts by groups such as the NCT to change social attitudes, but these have succeeded in little more than persuading a few shops and local authorities to provide facilities in public places for nursing away from the public gaze. In 1991 the local Council of the Borough in which many of the women in the study resided refused to implement a 'pro-breastfeeding policy' as proposed by the Joint Breastfeeding Initiative which would have required the Council to support a mother in the event of complaint about her breastfeeding in public (Ackerley, 1991).

Meanwhile babies continue to be shown being bottle-fed on TV programmes, dolls are still sold complete with feeding bottles, and a feeding bottle is still used as a symbol for babies in car rear windows and for baby-care facilities (including the spaces for breastfeeding mothers) in public places such as airports and shopping malls.

Women's breasts continue to be displayed in the media as objects of sexual attraction to men, and babies and children are still excluded from much public activity. Despite some advertising restrictions, the manufacturers of formula milks continue to promote their products, claiming the role of experts in child-feeding and of helpful allies of breastfeeding mothers rather than their rivals.

The fact that, despite the many disincentives, so many women in this study wanted to breastfeed, and that those who did manage to establish breastfeeding found it in many ways a satisfying and rewarding experience, suggests that if the various socially created obstacles and disincentives were removed, breastfeeding rates would go up. Van Esterik (1989) has argued that social conditions which favour breastfeeding are also conditions which favour the health, autonomy and self-confidence of women. This is supported by the fact that the women in the study who were most successful at establishing breastfeeding were in general the most self-confident, self-determining and financially advantaged.

Therefore, on the question of whether feminism should be pro-breastfeeding, the conclusion I come to is that society should be organised in a way which enables women to breastfeed rather than a judgement that women ought to breastfeed. This would include eliminating the ways in which breastfeeding is culturally de-valued, but, in view of what has been said about the potential of the natural ideal to contribute to women's oppression, breastfeeding should not be elevated above other means of human self-fulfilment, and there should be no suggestion that if women choose not to be mothers, or choose to bottle-feed either partially or completely, they have thereby gone against their natural 'destiny' and can never therefore be completely fulfilled as women.

Although I have said that society should be organised differently to accommodate

breastfeeding, if I attempt to make utopian recommendations I run the same risk of imposing a particular view in a positivist way as one does with the natural ideal. I therefore end with a few modest recommendations which I hope take account of the context of the sorts of problems the mothers in the study actually faced. These are in addition to the efforts being made to disseminate knowledge of the benefits and practicalities of breastfeeding.

1. Implementation of the WHO Code on marketing artificial baby foods.
2. Challenging the primary definition of women's breasts in terms of sexual attractiveness to men, and establishing breastfeeding as a socially acceptable, and normal, activity. Organised mass breastfeeding by mothers in public places can make a point, but the mass media could make an important contribution by featuring breastfeeding as a normal activity, for instance as an everyday background activity in domestic scenes which is simply there without being the focus of attention. The fact that the one woman in the study who set out to challenge public attitudes by feeding in the most public places met with some expressions of approval from strangers shows that the sight of breastfeeding is not universally condemned. This suggests that if this approval could be positively established as the dominant attitude, and women could feel that they would be supported in the face of criticism, then social norms could be changed in the same way that non-smokers' right to clean air is gaining precedence over the smokers' right to smoke wherever they choose. Measures such as the adoption by local Councils of the 'pro-breastfeeding policy' proposed by the Joint Breastfeeding Initiative (Ackerley, 1991) would help.
3. Measures to make combining breastfeeding with employment easier, such as flexible maternity leave, creches close by the work-place, flexibility for 'nursing breaks'

so that women can feed during working hours, etc.

4. Although acceptance of breastfeeding in public could in time reduce the numbers of women who feel personally embarrassed, nevertheless women should not feel forced to feed in public. Facilities should therefore be provided in public places for privacy. These could be combined with facilities for other aspects of baby-care, e.g. nappy-changing, heating feeding bottles, etc.
5. Although the natural ideal does provide a coherent framework of ideas for the practicalities of breastfeeding, the evidence in the study of women managing the difficulties of breastfeeding by combining it with bottle-feeding, and then sometimes continuing to breastfeed longer than anticipated (e.g. Françoise, Connie), suggests that knowledge of how to combine breast with bottle-feeding could help women to continue breastfeeding. Of course women should be aware that feeding from a teat (or a nipple shield) could accustom the baby to an inappropriate latch for breastfeeding, and that bottle-feeding means less stimulation of the mother's milk supply, but there was plenty of evidence in the study of breastfeeding successfully being established despite bottle-feeds and nipple shields. Women in the study therefore suffered unnecessary anxiety through being told (amongst their conflicting advice) that bottle-feeding or the use of nipple shields would spoil their chances of breastfeeding, or that one should either breast or bottle-feed but not both. The problem of maternity personnel not understanding how babies should latch on to the breast is being addressed, but attention should also be paid to how babies can adjust to both types of feeding so that this too can be imparted to mothers, together with an understanding of how to manage demand and supply, so that they can make their own choices.
6. Mothers could also benefit from more informed guidance on how to express milk

(both by hand and by pump). Many women in the study had reason to express (e.g. for dealing with problems of engorgement or sore nipples, or for converting breastfeeding into bottle-feeding), and an understanding that milk could well not be expressed at the same rate or in the same quantities as the baby would get by sucking, would have saved many women the anxiety of being led to believe that their milk supply was inadequate.




7. Mothers could also be helped to brave breastfeeding in public if there were more awareness that with skill it need not be particularly visible or noticeable. Demonstrations at ante-natal classes of feeding behind shawls or bulky jackets, or under big sweat shirts, etc. could give mothers more confidence to feed in public places.

**APPENDIX 1: STEPS IN DEVISING A SOCIAL CLASS CLASSIFICATION  
INCORPORATING OCCUPATIONS OF MOTHERS  
AND THEIR HUSBANDS AND MOTHERS' EDUCATION  
(See Chapter 6, Section 6.1.4)**

TABLE A1.1: CLASSIFICATION OF OCCUPATIONS				
REGISTRAR GENERAL'S CLASSIFICATION		CLASSIFICATION IN THIS STUDY	FREQUENCY	
Class Band	Type of Occupation	Class	Husband	Mother
1	Professional and higher administrative	I Upper Middle	12	5
2	Intermediate professional and administrative			
3N	Skilled non-manual	II Lower Middle	15	28
3M	Skilled manual	III Working	20	14
4	Semi-skilled			
5	Unskilled			
TOTAL				47

Table A1.2: CLASSIFICATION BY EDUCATIONAL ATTAINMENT		
Type of Qualification	Class	Frequency
First and higher degrees, and higher professional qualifications	I Upper Middle	9
A-level, lower professional and technician qualifications	II Lower Middle	14
O-level, CSE and craft level qualifications	III Working	24
	TOTAL	47

TABLE A1.3: DISTRIBUTION OF SAMPLE BY COMPOSITE SOCIAL CLASS (combining husband's occupation, mother's occupation and mother's education)										
Husband	I			II			III			
Mother	I	II	III	I	II	III	I	II	III	TOTAL
Education										
I	4	3			2					9
II		4		1	6			3		14
III		1			4	2		5	12	24
TOTALS	4	8	0	1	12	2	0	8	12	47

-  Class I (Upper Middle)  
 Class II (Lower Middle)  
 Class III (Working)

## APPENDIX 2: RECRUITMENT LETTERS

LETTER A2.1 (distributed to NCT members and women introduced by mutual acquaintances)

Tel: 0483-722949

44 Inglewood  
Woking  
Surrey  
GU21 3HX

March 1985

### INFANT FEEDING

I am a part-time post-graduate student with the Open University, doing research on infant feeding from the mother's point of view. I want to study the kinds of problems that new mothers in our society face as they care for their babies, especially as these affect feeding. The aim is to conduct a series of three interviews with each mother in the study, one about a month before the baby is born, the second a month after the birth and a third when the baby is about five months. Each interview would last about 45 minutes, and would take place in the mother's own home (unless she preferred a different place) at a time convenient to the mother.

The mothers' identities and the information given will be strictly confidential and known only to me. Nothing will be written in the final report which could be traced to any individual person.

A bit about myself - I am 39, married, with three children, Helen (10), Alex (6) and Michael (3). I became interested in this topic for research through my own experiences as a mother.

I would be very grateful indeed for any help in this project, and would be delighted to make contact with any woman who is expecting her first baby and is willing to be interviewed.

Please do not hesitate to contact me if you would like more information.

Celia Dyball



LETTER A2.2 (distributed at hospital)

Tel: 0483-722949

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GU21 3HX

July 1986

INFANT FEEDING

I am a part-time post-graduate student with the Open University, doing research on infant feeding from the mother's point of view. I want to study the kinds of problems that new mothers in our society face as they care for their babies, especially as these affect feeding. The aim is to conduct a series of three interviews with each mother in the study, one about a month before the baby is born, the second a month after the birth and a third when the baby is about five months. Each interview would last about 45 minutes, and would take place in the mother's own home (unless she preferred a different place) at a time convenient to the mother.

The personnel at (*name deleted*) Hospital are kindly allowing me to introduce myself to expectant mothers attending their ante-natal clinics, in order to ask for your assistance. Your participation in this project is completely voluntary and I would be very grateful for your help. The mothers' identities and the information given will be strictly confidential and known only to me. Nothing will be written in the final report which could be traced to any individual person.

A bit about myself - I am 40, married, with three children, Helen (11), Alex (7) and Michael (4). I became interested in this topic for research through my own experiences as a mother.

I shall be at the clinic today and will be pleased to talk to you about my project. If you wish to give me your telephone number and/or address I can contact you again to arrange the first interview. I do hope you will want to help me as every mother's experiences are important in gaining as full a picture as possible of what it is like to feed a new baby.

Celia Dyball

**APPENDIX 3: INTERVIEW GUIDES**

**A3.1: FACE SHEET**

NAME

ADDRESS

TELEPHONE NUMBER

EXPECTED DATE OF DELIVERY

AGE

MARITAL STATUS

HOW LONG MARRIED

HOW LONG AT PRESENT ADDRESS

HOUSING STATUS

(owner/occupier, Council rented, private rented, living with relatives, etc.)

TYPE OF DWELLING

(house, flat, etc.; approx. size)

OCCUPATION

EDUCATION

HUSBAND'S OCCUPATION

SPECIAL INTERESTS/HOBBIES ETC.

DATE OF FIRST INTERVIEW

DATE OF DELIVERY

BABY'S WEIGHT

TYPE OF DELIVERY

BABY'S SEX

BABY'S NAME

A3.2: INTERVIEW GUIDE - FIRST INTERVIEW

The first interview always began with the question: HAVE YOU THOUGHT MUCH ABOUT FEEDING YOUR BABY?

After that there were no pre-formulated questions, but the topics covered were as follows.

Decisions about feeding method and reasons. Advantages and disadvantages of breast and bottle-feeding. Sources of information on feeding.

Mother's feelings about becoming a mother in general. Husband's reactions. Reactions of friends and relatives.

What ante-natal care is the mother receiving? Mother's feelings about her ante-natal care. Do ante-natal health carers talk about feeding? Mother's view of their attitudes to breast and bottle-feeding. Mother's opinion of usefulness/influence of ante-natal carers with regard to feeding.

NHS ante-natal classes. Mother's opinion in general. Has feeding been covered? Mother's view of attitudes to breast and bottle-feeding of class teachers. Mother's opinion of usefulness/influence with regard to feeding.

Contact with NCT, La Leche or similar? Mother's opinion in general. Has feeding been covered? Mother's view of attitudes to breast and bottle-feeding of class teachers. Mother's opinion of usefulness/influence with regard to feeding.

Any discussions about feeding with friends and relatives? Their attitudes to breast and bottle-feeding. Mother's opinion of usefulness/influence with regard to feeding.

Any other sources of information or advice about feeding? Probe for how actively sought. Mother's opinion of usefulness/influence with regard to feeding.

Any conflicting ideas about feeding?

Any special preparations being made by mother now for feeding?

Previous experience with babies. Mother's assessment of her own self-confidence with regard to feeding. How clearly can the mother imagine what feeding will be like? Anticipated problems/pleasures etc.

Sources of lay help after return from hospital, and what the mother expects to need from them.

A3.3: INTERVIEW GUIDE - SECOND INTERVIEWbirth

type of delivery  
 feelings and impressions about delivery  
 husband's reactions  
 first impressions of baby - what, when

feeding in hospital

first feeding                      - what  
    timing  
    help needed/given/available  
    impressions

second feeding                - what  
   and so on                            timing  
   according to                    help needed/given/available  
   mother's                            impressions  
   memory

other substances fed to baby

problems                      - baby's feeding  
    sore nipples, engorgement, etc.  
    mother's physical condition  
    baby's physical condition  
    drugs  
    other

expressing milk

attitude of hospital staff to breast/bottle

rooming in

demand/schedule feeding

weighing/test weighing

discussions with other mothers

experiences/attitudes of other mothers

good and bad points about being in hospital

**mother's opinion of usefulness of hospital stay with regard to feeding**

**conflicting advice**

feelings about giving up breastfeeding if applicable

home

length of hospital stay

**sorry/glad to leave**

**expectation and reality of coming home - more/less confident?**

**was feeding different at home?**

any changes made by mother in feeding at home

problems with feeding

## other problems

feelings about giving up breastfeeding if applicable

### sources of help

**husband**

midwives

**health visitor**

GP

**relatives/friends**

NCT

**clinic**

books, leaflets, etc.

**conflicting advice**

feeding now

how is feeding going now - when  
what  
how  
where  
who

- level of satisfaction
  - baby's feeding
  - general progress
  - does mother like being a mother?
  - does mother like feeding her baby?

weighing

good/bad feeds

good/bad days

how are (or have been) problems solved? remedies

centrality of feeding - household routines fitted around baby, or baby's demands fitted into routines

management of visitors, going out, etc.

assessment of advantages/disadvantages of breast/bottle

looking ahead

how long intending/expecting to breastfeed?

any thoughts on introducing supplements?

any thoughts on introducing solids?

### A3.4: INTERVIEW GUIDE - THIRD INTERVIEW

#### Feeding

Remind and confirm with mother summary of how baby was being fed at last interview.

How is baby being fed now?

- breast
- bottle
- water
- juices
- vitamin supplements
- solids
- other

Any problems since last interview.

If breast has stopped since last interview

- when
- why
- any advice in the matter?
- feelings about stopping

If started feeding solids

- when
- why at that time
- any advice in the matter
- how
- problems
- mother's feelings
- relationship to breast/bottle now
- advantages/disadvantages of solids

If not feeding solids

- any attempts so far
- anticipated time of introduction
- reasons for timing
- advice in the matter
- mother's anticipations and feelings

Mother's anticipations of completion of weaning (from breast or bottle). When.  
Reasons. Advice in the matter.

#### Sources of help and advice

Health Visitor  
GP  
clinic  
NCT

husband  
friends/relatives  
leaflets, books, magazines, etc.  
other sources of information or help

what sort of help/advice?  
mother's assessment of usefulness

General progress

level of satisfaction with baby's progress  
good/bad days  
levels of satisfaction with being a mother

Looking back and forward

Any plans for returning to work (if not already returned).

Mother's anticipations of how feeding will progress from here.

Looking back, does mother wish anything had been different, or wished she had done anything differently?

Assessment of breast and bottle-feeding advantages/disadvantages

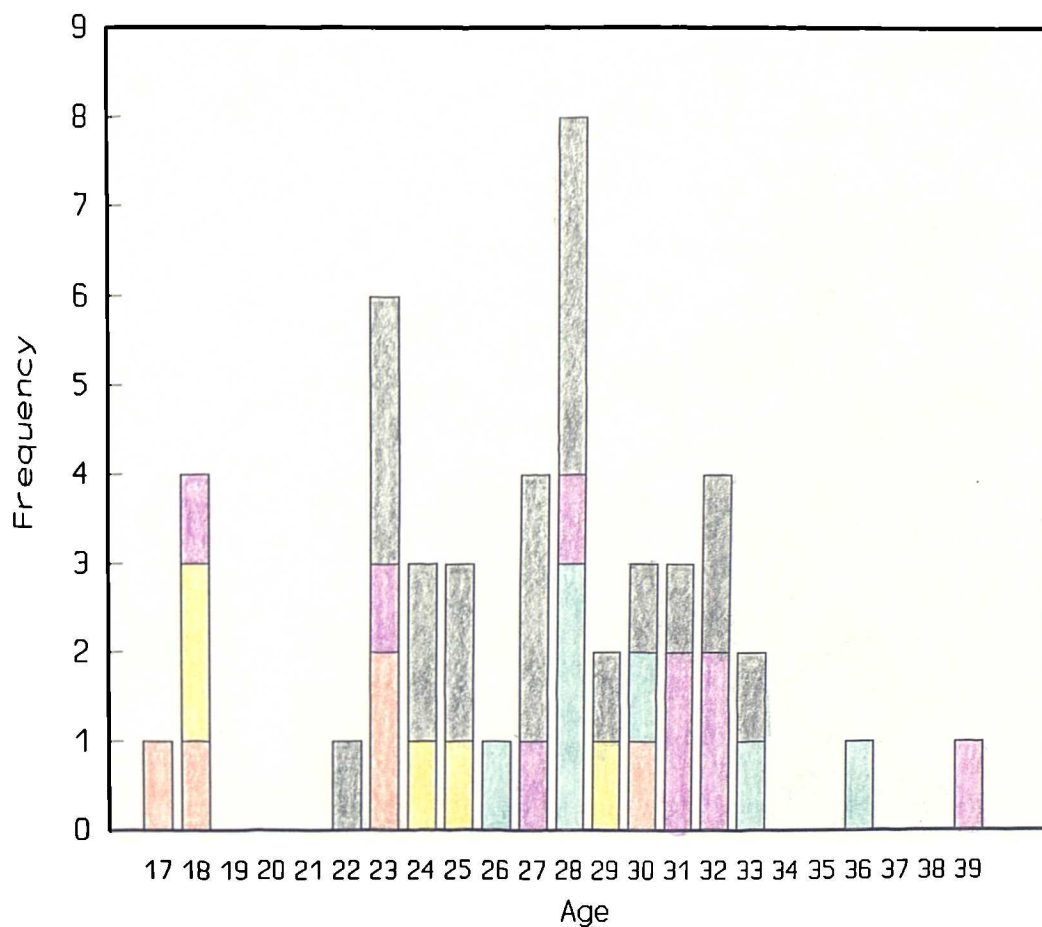
Anticipations for future babies, and intentions about feeding methods.

Ask mother what advice she could give to a new mother based on her own experience.



**APPENDIX 4: SOCIAL CLASS AND FEEDING CAREER PHASES**

TABLE A4: LIST OF MOTHERS BY SOCIAL CLASS AND FEEDING CAREER PHASES			
<u>Class III</u>	<u>Class II</u>	<u>Class I</u>	<u>Feeding Phase</u>
Lorraine Fay Brenda Diana Trudie			No attempt to breastfeed (5)
Nina Kay Tracey Margaret	Pamela Priscilla Stella		Gave up breastfeeding in hospital (7)
Mandy Joy Barbie	Fenella Tammy		Gave up breastfeeding by three weeks (5)
Milly Fern	Simone Françoise Irene Connie Samantha	Roberta Sarah	Gave up breastfeeding early weaning period (before 5½ months) (9)
Michelina Donna Pauline Gaynor Cynthia	Anneka Andrea Hilary Isobel Nancy Edwina Sheena Ruth Maureen Angela Tabitha	Vanessa Audrey Valerie Gwen Marcia	Gave up breastfeeding in completion of weaning period (after six months) (21)
(19)	(21)	(7)	(47)






**APPENDIX 5: AGE/FEEDING CAREER PHASES****LEGEND**

- Phase 1: no attempt to breastfeed
- Phase 2: gave up breastfeeding in hospital
- Phase 3: gave up breastfeeding by three weeks
- Phase 4: gave up breastfeeding in early weaning period (before 5½ months)
- Phase 5: gave up breastfeeding in completion of weaning period (after six months)





Figure A5: AGE/FEEDING CAREER PHASES


## **APPENDIX 6: CAREER CHARTS** **(see Chapter 6, Section 6.4)**

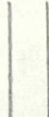
### **LEGEND**






-  breastfeeding
-  expressed breast milk (donated or mother's own)  
fed by bottle
-  formula milk by bottle
-  'solids'
-  arrow denotes continuing line

### **intentions before birth:**

-  to breastfeed
-  to bottle-feed (formula milk)
-  combination of breast and bottle-feeding (formula milk)
-  undecided

 Single vertical line denotes discharge from hospital of mother and baby.

 When two vertical lines appear, the first denotes mother's discharge from hospital, the second the baby's after being retained in Special Care.

MOTHER AGE CLASS INTENTION	PHASE 1: BEFORE BIRTH DECIDING NOT TO BREASTFEED												SHEET (i)
Lorraine 18 III 								↑	↑				
Fay 17 III 								↑	↑				
Brenda 30 III 								↑	↑				
Diana 23 III 								↑	↑				
Trudie 23 III 								↑	↑				
													Time (Months)

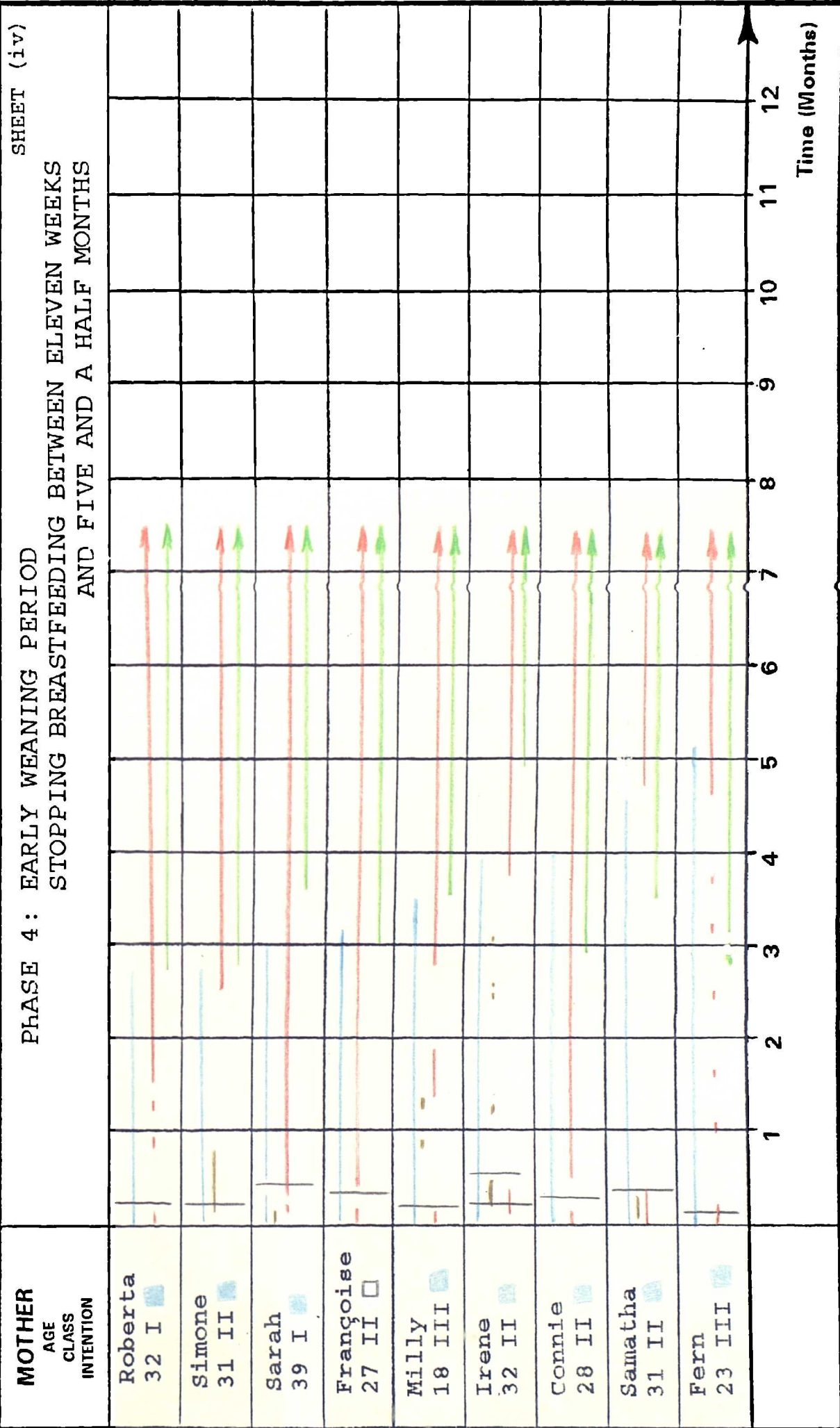
PHASE 2: IN HOSPITAL  
STOPPING BREASTFEEDING BEFORE DISCHARGE

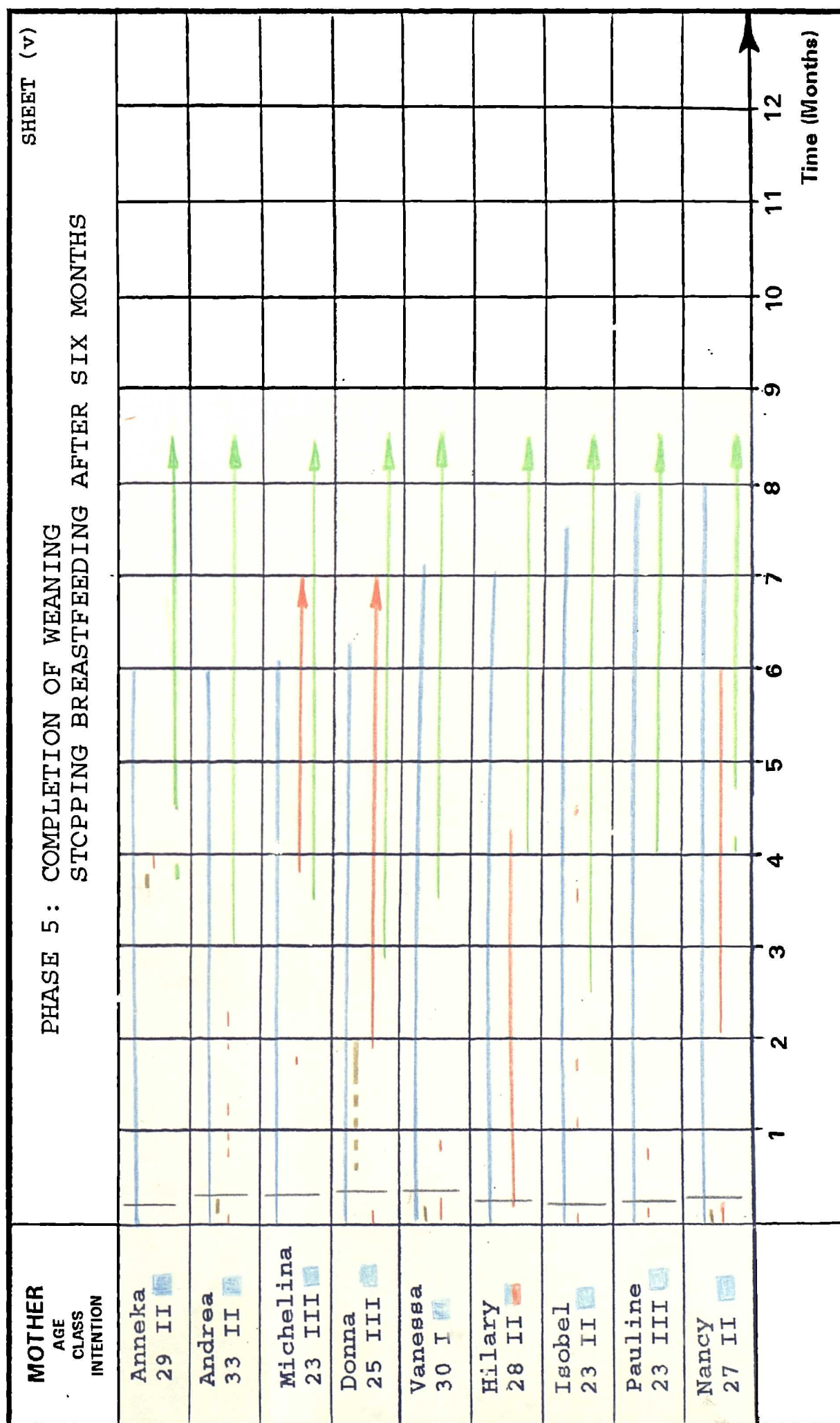
	Time (Months)	7	8	9	10	11	12
Pamela 28 II [ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Priscilla 33 II [ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Nina 28 III [ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Kay 26 III [ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Tracey 28 III [ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Margaret 30 III [ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Stella 36 II [ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]

# STOPPING BREASTFEEDING THREE WEEKS AND UNDER

[illegible]

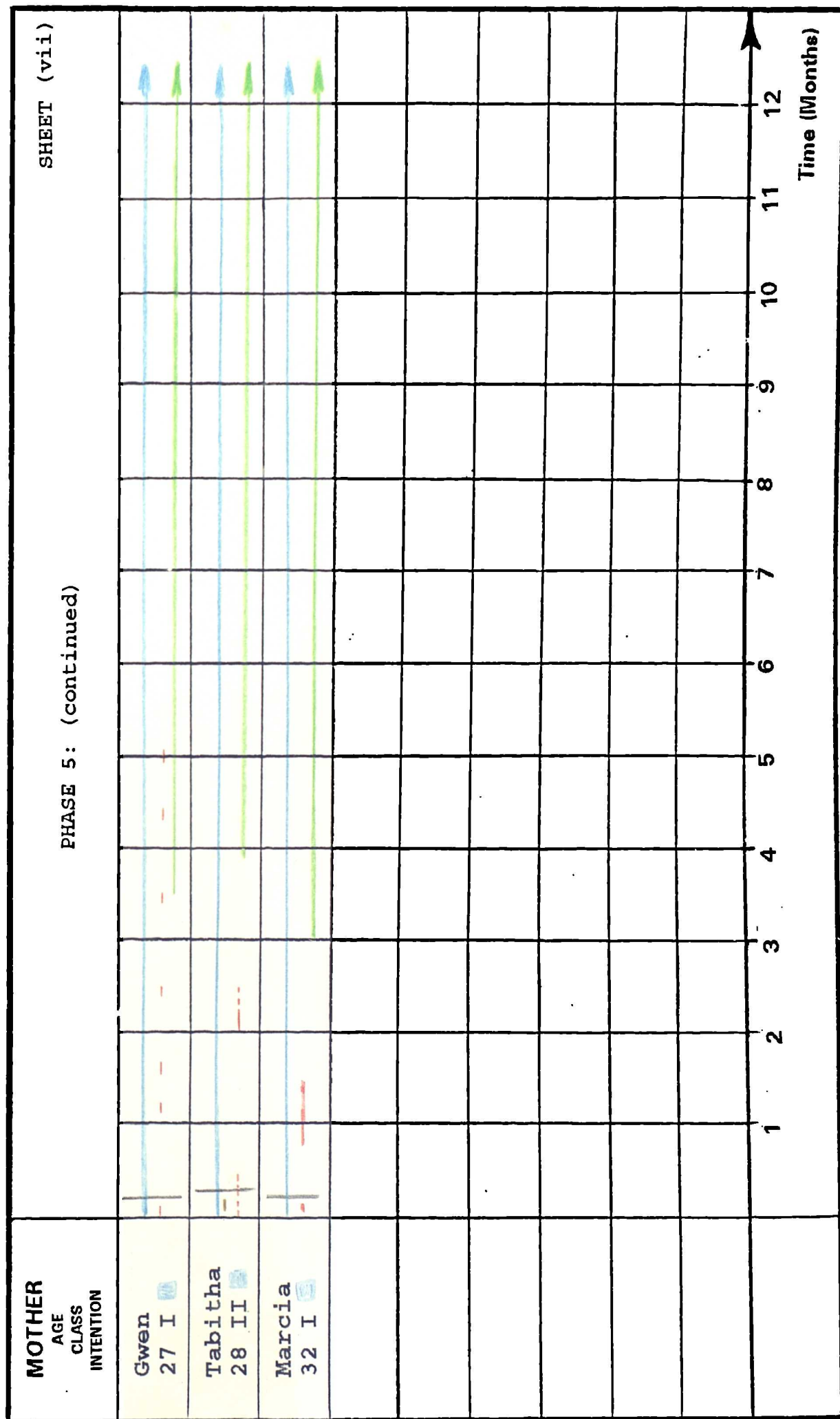








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